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Maine Medical Association meets at Augusta, June, 1920

THE JOURNAL



Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. X, No. 1

AUGUST, 1919.

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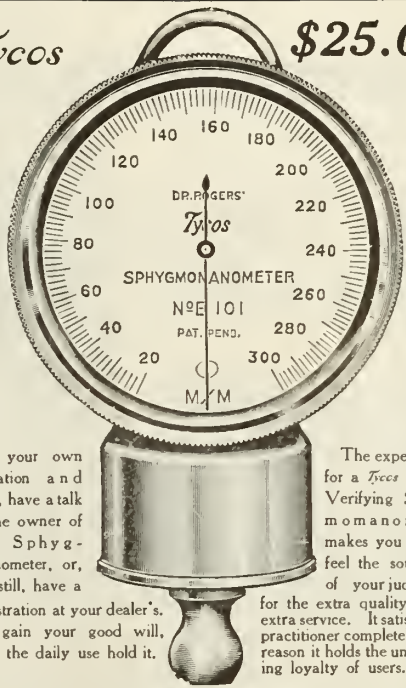
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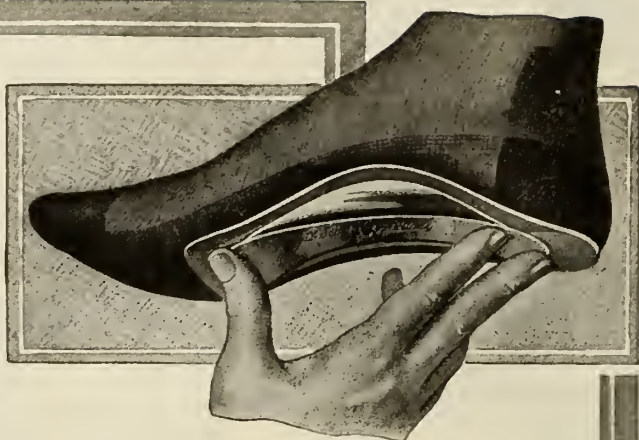
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VOL. X.

AUGUST, 1919.

No. 1

*PRESIDENT'S ADDRESS.

By DR. GEORGE COOMBS, Waldoboro, Me.

Members of the Maine Medical Association:

Last year at this time we were taken up, individually and collectively, with the appeal that had come to us from those engaged in the work of enrolling doctors for the adequate care of our armies at home and abroad, and for the care of those who manned the ships of our navy and of that bridge of ships which put across the greatest job of military transportation that the world has ever known. More than one-fourth of the doctors in Maine and of this Association responded to the call for duty in the navy, in camps, or across seas, and we know that they fully carried out the traditions of the state and of this society.

We esteem it a high privilege indeed to stand here to-day and give them a "Welcome Home," and to assure them face to face of the great appreciation which has everywhere been spoken of their work and of their sacrifices. To those who are finishing the task, and who are still across seas or in camp because of their especial fitness for these duties, I know you join with me in the message of the greatest regard and in the heartiest wishes for their speedy and safe return. To many of those whose lot it was to remain at home came the work of the draft boards, and to all came the extra duties and cares of public and private health work which for many months of the epidemic seemed almost more than they could carry on.

* Read before June meeting Maine Medical Association at 1919 session.

The toll of the Reaper in camp and on the battle field has been equalled in the medical forces at home. Our necrologist has called them by name, and we as an association tender to their loved ones our heartfelt sympathy for their loss and our joy that it had been our lot to know them.

By ones and by twos our members are again taking up the work at home, and to those of us who were privileged to remain in the midst of our daily duties comes the rare opportunity of turning back to them all the interests belonging to them with which we have been associated. In the field of medicine, as in all other walks of life, a re-adjustment of forces is taking place.

Membership in state or national associations of any branch of public or private service is ever accompanied by responsibilities as well as privileges. The beginner in all lines learns to look upon membership in these associations as his first goal, and it is the privilege of those already members to have raised and kept the standards of that association at its highest point of professional excellence. To this end, and in particular in this association, it is plainly evident that upon each member of this body and its constituent branches is a personal responsibility which covers attendance at every meeting, participation in the same, and every effort to maintain the standard set up by our forebears. We may well ask ourselves the very personal question if we have given back to our state and county associations full measure in return for the advantages acquired in becoming members.

There has developed an amount of general criticism of our custom of having our delegate to the American Medical Association serve for but one year, that delegate being the retiring President. We present to you with full force the belief that this custom is not for the best interests of this Association and urge that the matter of electing a delegate for two years, in accordance with the by-laws of the parent association, be taken up at this session with the proviso that it be permissible, if conditions so demand, that a second term of two years be given. We also suggest that it is in the line of securing interest and positive service in this direction that all expenses, or at least the traveling expenses, of such delegate be paid by this association.

It is with pride that we call to your attention the change in the public health laws enacted by the Legislature at the last session and to the loyal support of the physicians who are members of the General Court, and also to their hearty support of measures destined to affect us as a body.

The law passed giving the superintendents of our state hospitals

power to receive for a period of fifteen days persons mentally unbalanced for the purpose of examination is one of great advancement in the care of these unfortunates and leads us to hope that in the near future all cases of mental disorders may be under observation of trained alienists for a sufficient time to determine the best method of care, often obviating the stigma of commitment to an insane hospital of those better cared for elsewhere, in other words, a psychopathic hospital for preliminary diagnosis.

The law prohibiting the marriage of syphilitics while contagious appeals to us as an advance of immense importance, and the work of the federal public health service makes one feel that it will not be a dead letter.

The experiences of the past winter lead to certain definite personal conclusions that there is a great deal of improvement yet to be sought for with relation to the control of those who practice the healing art in this State. In the past, to a certain extent, we have been meeting the action of certain cults in the Legislature. Now, if ever, is the time when we owe to the people of this State and to ourselves as a body that we take up this matter, not from the point of defensive action, but by constructive work, so that this state shall have but one standard of preliminary and scientific education for those who are permitted to practice the healing art for gain or hire. As has been said, we have been pauperizing the American public in doing their thinking for them in this direction, and in return for this are ever met with the accusation of self-interest. Few think, in their criticisms, that it is not the doctor who is to be practiced upon by these cults but the people, the protection being for the public and not the medical profession, and now there is a well-defined belief throughout the profession that to the people should be remanded with great emphasis the problem of the standard under which all such persons should be allowed to practice. We cannot and do not lay claim to any exclusive type of therapeutics, but we do insist upon that which the standard diagnosis depends and upon which all treatment is based shall be the same for one and all. Some believe that medical men should control their own profession, while others believe that their work in this direction should be advisory. We cannot lose sight of the fact that these people as citizens have the same right to earn an *honest*—and we emphasize “honest”—living that we have, but if their practices encroach upon the bounds of public safety then they must conform to the same standards demanded of all.

The courts of Maine rendered a decision in the case of a clairvoyant many years ago, that he who visits the sick, examines the patient,

makes a diagnosis and prescribes a treatment, for gain or hire, is practicing medicine. In spite of this, Section 16, Chapter 18, R. S., exempts clairvoyants, persons practicing hypnotism, magnetic healing, mind cure, massage, Christian science, osteopathy, or any other medical healing or prescribing, if no poisonous or dangerous drugs are employed nor surgical operation performed; provided, such clairvoyant or other persons do not violate any of the provisions of the preceding section in relation to the use of M. D. or Dr. or the title of doctor or physician.

This is distinctly a section intended to shield a certain type of individuals who are, in fact and in deed, practicing medicine, and who have not acquired sufficient preliminary and scientific education to make them qualified to judge if their particular type of treatment is safeguarding the interests of the individual and of the public. It seems as if now is the time in which every member of this association has a duty that he cannot, in justice to himself, to his neighbor physician and to the public, neglect, namely, to take on an intensive campaign of education himself, in his own community, before the time arrives for new legislation, to the end that the public shall be made aware that the requirements of practicing the healing art in this state is one thing for him who possesses a license from the State to practice medicine, and another thing for those who, while professing to make marvelous cures, have not conformed to the standard which every citizen has a right to believe should be demanded of them. The time to take this up with your Legislative Committee is now, not in December, 1920. You, as an individual, have this definite duty, and we, as a body, have the duty to society and ourselves, that from now on an aggressive campaign be carried on in gathering facts which may be presented to the proper committee of the Legislature as reasons why this law shall be corrected.

It is the experience, I believe, of all physicians that, in the long run, the work of these irregular practitioners has a distinct financial gain to the registered physician, but the toll of physical and economic loss is so great that we are in duty bound to work to the end that one standard be accepted for this state. The osteopathic registration law, as passed, seemed to safeguard, so far as was possible at that time, these interests, and the elimination from the bill of the section declaring that the practice of osteopathy was not the practice of medicine seemed to safeguard the element of legal responsibility for their services. That other one-system therapists will soon demand recognition also is very evident, and again we come back to the proposition that he who practices the healing art should conform to one standard of education. We should prepare for this and present to the Legislature a bill, which, while it

recognizes the right of the individual to control his own destinies therapeutically, shall provide that he who professes to relieve and cure ills of the human body by any method whatever shall conform to one standard of education before assuming the ability to diagnosis and therefore the ability to treat the condition.

And, too, there is a field for a vast deal of educational work to the end that the medical advertising of our newspapers shall contain only such matter as the paper in which it appears is willing to guarantee. It does seem as if, could it be possible to place the record of the examination by the Council of Pharmacy of the American Medical Association of the majority of preparations and remedies exploited in the lay press before the business managers of these papers, they would be refused space. The medical advertisements served up to us in the papers of this state are a disgrace and a blot upon the fair name of our state. It appears at present, however, that the only slogan of the managers of these papers is to get all the good advertising they can get, but to be sure and get it.

The Workmen's Compensation Act, in which we are all vitally interested, but in degree as we may or may not live in the vicinity of manufacturing plants, received changes, possibly it may be called improvements—we think not—resulting from the compilation of the demands of eleven separate bills. This new Act was reported to the Legislature at the eleventh hour of its session, so near its close, in fact, that no opportunity for discussion was possible. Before the committee a claim was made that the waiting period prohibiting the giving of compensation until fourteen days after the injury was absolutely necessary to prevent malingering. In other words, those who advocated this waiting period stood out to brand the American workman with the mark of dishonesty in every case, or in order to deter one or two or a few from becoming malingerers, they were willing that gross injustice should be done to the mass of the workmen of this State who are so unfortunate as to have been injured. We, as physicians, know that the time when an injured workman and his family need assurance of financial help is, above all else, at the time of, *the hour* of the injury. It seems that every physician who becomes aware of hardship occurring as a result of this section, even with the waiting period reduced to ten days, should make note of all facts connected therewith and report them to the Legislative Committee of this association. The section applying to the choice of medical attendant has been corrected in part, but still takes from the workman that choice of action which we believe the rights of personal liberty give to every citizen of this country. We are aware and

believe that the majority of the employers in this state are desirous of, and do, furnish superior medical and surgical attendance, but that there are abuses of this is plainly evident, and we believe that the personal consideration which applies to those physicians and surgeons who have been selected by these corporations to do this work will in the long run be better conserved, and the rights of the injured workman better protected, if he be given the absolute right to choose his own physician if he wishes.

We are receiving arguments pro and con for so-called medical insurance. The two countries in which this has been most thoroughly pushed are up against the fact that up to the present time it is a monumental failure, namely, Germany and England. Socialists and so-called uplifters are trying to force their views on the people and claiming that health insurance should at once be established in this country. Attractive though it may be to the laboring man, we believe that we can do no higher service to him than to show him that his interests, physically and morally, are far better safeguarded by his accepting the principle that he paid to an individual physician for the best type of service which he is capable of giving, at the time such service is given, than there will be if he pay a lump sum in advance for all services which he may need during the year.

These conditions seem of vital interest at this time. That we will sit quietly until a Legislature meets seems incredible. If we are to have our full measure of good we must look upon it as our personal business to study the question, and then, when the next session occurs, be prepared to add our contribution of suggestions of value for the Legislative Committee as a basis for action which will stand the approval of the entire membership of this body, and command the respect of the Legislature. Let me again emphasize this point, in another way, perhaps, that if we expect improvement in the laws under which we practice, and affecting those who are our patients, we have a responsibility which is personal and individual, and which we cannot delegate to anyone else or pass over with the idea that our association as an association will look after it, but it is up to us from now on to see to it that the committee appointed by the society is acquainted with every fact bearing upon these different conditions which have come to our attention.

Let me suggest that there appears to be a desire for a mid-winter session of this association, and that you think it over, and if perchance, meets with your approval, so register that approval to the end that a short, social meeting may be held somewhere in the state during the winter.

And now, gentle hearer, lest these words may lead you to believe that economic conditions affecting this association are unhappy, take heart in the knowledge that these conditions have always confronted us, but that now more than ever, the opportunity is with us to improve them. [Applause.]

***HOW TO REDUCE THE MORTALITY RATE IN CANCER.**

By W. M. SPEAR, M. D., F. A. C. S.

In presenting this paper I do not propose to give a scientific treatise on cancer, but rather to bring to your attention, and through you to the laity, the means at our disposal to reduce the high mortality from this disease. I am led to do this because of the exceedingly large number of patients who come to me suffering from a neglected cancer.

I believe statistics show that the death rate from cancer is on the increase throughout the world. In this country alone there are 80,000 deaths annually from this disease. Now stop and think what this means; it means that in people over forty years of age one woman out of every eight and one man out of every fourteen dies as a result of this disease.

Now, what can we do to reduce this death rate? To my mind one of the most important means at our disposal is to constantly talk to the laity and impress upon their minds the conditions which predispose to cancer, and also its earliest symptoms, persistently reiterating the fact that in its early stages cancer is curable. We as physicians must also bear these things in mind, for I regret to say that many deaths from this disease must be laid directly at the physician's door. If this is true he is not acting as a physician should, for he should advise the patient that in early surgery we have at our command practically the only means by which we can hold out to the patient hope of a permanent cure.

At first, cancer is always a local disease, and I am going to touch on a few of the earliest symptoms which lead one to suspect cancer and the conditions which, while benign at the time of examination, may eventually become cancer.

First, I am going to speak of the uterus, as that is one of the most frequent seats of cancer, one in which we can do a great deal in the way of prophylaxis and also hold out a reasonable certainty of cure,

* Read before annual session Maine Medical Association.

provided the diagnosis and operation are made early in the disease. This is usually an easy matter in nearly all cases of cancer of the uterus. All unhealed lacerations or erosions of the cervix should be taken under careful consideration and if necessary, treatment or a slight operation undertaken in order to prevent irritation, which we know is a fruitful cause of cancer. An increase of flow at or about the time of the menopause, while in itself not at all unusual, must be looked upon with suspicion, also a change in the character of the discharge, particularly if it is of a thin, watery nature, slightly stained with blood, and pain, bladder or rectal irritability. These are among the earliest and most important local symptoms for the purposes of diagnosis, and when present we should insist on a thorough examination, as they are often the first symptoms of a pathological change in the tissues, the most common result of which is cancer, fibroid or a polyp.

When a patient comes to you with any of the foregoing conditions, don't, I beg of you, say to her, "This condition is natural, probably due to the change of life," give her a little medicine, send her home and tell her to forget it. This has been done many, many times in the past, and will undoubtedly be done many times in the future, but I sincerely hope that the practice will grow less as our knowledge of this disease increases and that the time will soon come when a patient will insist upon a thorough examination or consult another physician. If, upon examination, you cannot account for the condition, state it frankly to the patient, and insist upon a consultation.

When such a patient is referred to me, and if, after a thorough examination, the symptoms point toward malignancy, I state to the patient as plainly as possible the conditions and advise radical operation. To some of you this may seem like an extreme step, but I was led to adopt it by several unfortunate experiences. Formerly I would remove a portion of the involved tissue and have the pathologist make a frozen section at once and govern the operation according to his report. This was apparently very successful for a time, or until several patients, upon whom the report had been negative, died within twelve or eighteen months from cancer. This happened in specimens removed from the uterus, breast and neck. Then I made up my mind that it was time to change my methods, and while I know that in some cases I have performed an unnecessary radical operation, I also know that I have saved many patients from suffering and death.

Do not for a moment think that I am blaming the pathologists, for such is not the case. Probably the small specimens submitted to them did not contain the evidence of malignancy, but undoubtedly, if they

had had the entire specimen and examined it at their leisure, such evidence would have been found.

I must say a few words about those patients suffering from cancer of the uterus which has reached the stage we call inoperable, those with a large, bleeding, sloughing cervix, accompanied by a very foul vaginal discharge and some extension of the growth on to the vaginal wall. Don't send such a patient home without a ray of hope, condemned to a life of suffering until relieved by death. We can do much for them in the way of both mental and physical relief, and in very rare cases obtain a cure. To such a patient I frankly state the exact condition, that I cannot hold out much hope of a cure, but that I can probably give her some relief and prolong her life for a number of months. If she consents, which she nearly always does, I then give her a very thorough treatment with the actual cautery and ask her to report to me in several months. By this method many of the inoperable cases are given a comfortable life for many months, free from pain and foul discharge. In most cases, after this treatment, you will be surprised to see the great amount of shrinkage which takes place in the growth, and occasionally to such an extent as to justify a radical operation.

Several years ago a patient consulted me for what I considered an inoperable cancer of the uterus. The cautery was used, and at the same time a specimen sent for pathological examination, the report on which was carcinoma of the uterus. She reported in three or four months after the operation, and on examination I found the condition such that I deemed a radical operation justified. This was done and the patient is now alive and well without symptoms of recurrence. It may interest you to know that the entire uterus and adnexa were sent to the pathologist, who reported that there was no evidence of malignancy, only scar tissue.

The breast is another favorite location for the development of cancer, one where it is easily discovered and a reasonable hope of cure may be entertained if treatment is undertaken early. What I have said about the cancerous and pre-cancerous conditions of the uterus holds true in this location, but if anything, the disease spreads more rapidly from this locality. Any lump appearing in the breast at any age is a sign of danger and in my opinion should be removed. If the patient consults you when the bunch is first noticed, she will probably say, "Doctor, I don't think it is cancer, because it is not painful," then you must clearly explain to the patient that cancer during its curable stage is not painful. If we can only make the laity understand this fact, we will have accomplished a great deal toward reducing the mortality from this disease. If the patient is over thirty we must be exceedingly careful in our diag-

nosis, and in my opinion if there are any symptoms indicating cancer, a radical operation should be advised. If a bunch is present at about this age, or under, and if after a careful examination we are unable to find any symptoms pointing to cancer, then we are justified in performing a slight operation to remove the growth, but if after removal it shows the slightest indications of cancer, a radical operation should be performed at once. I believe that if the symptoms and physical examination point in the least to cancer, it is far better to perform a radical operation at once than to remove the growth for diagnostic purposes with the intention of doing a radical later. This latter method of procedure I most thoroughly condemn.

Recently a woman from a neighboring town consulted me about a bunch in her breast. The bunch appeared six months ago and felt about the size of a pea. Two months later she consulted a physician, who told her to go home and forget it, but being a woman with plenty of hard common sense, and having read somewhere about the dangers incident to a bunch in the female breast, she consulted a physician in one of our larger cities, and he, evidently thinking her general condition of more importance than the bunch, treated her, but at the same time told her that he would watch the bunch and at the first sign of malignancy advise her what to do. After several weeks she again became dissatisfied and consulted a physician, who told her that she ought to have it removed at once. I then saw her for the first time, and found a woman thirty-five years old, slight, anæmic, with a slight heart murmur, hæmoglobin 58, and a hard bunch about the size of an acorn just above the nipple in the left breast. After a careful examination I advised a radical operation. Operation was accepted and the pathologist reported carcinoma. I think that I am perfectly safe in making the statement that when a bunch appears in the breast of a woman thirty-five or more years of age, that over ninety per cent. of them are cancer and probably nearly all of them are cancer from the beginning.

I have spoken at some length on cancer of the uterus and breast because these organs are so frequently the seat of this disease, and as a rule we can diagnose the condition early and advise operation with a reasonable hope of cure.

In cancer of the stomach and intestines we have a more difficult condition, for the onset of the disease is so insidious that it is very frequently overlooked until too late. I think it is safe to say, as a general rule, that when the physical signs are unmistakable, then it is too late to hope for a permanent cure, although we may do a great deal for the comfort of the patient as well as prolong his or her life. If your pa-

tient is at the cancerous age and is suffering from chronic indigestion, nausea and vomiting, constipation which is not constant, possibly an occasional attack of diarrhoea, occasional attacks of abdominal pain becoming more frequent and which may last for a few minutes or several hours, then think of cancer of the stomach or intestines and give the patient the benefit of the appliances of modern medical science, especially the X-rays. The same thing applies here as elsewhere, that early operation offers the only hope of cure. When the symptoms are suspicious we are certainly justified in advising an exploratory operation, for after all is said and done this may be the only sure method of making a correct diagnosis and saving the life of the patient.

How many of us have had a person stop us on the street or come into our office and say, "Doctor, my piles are troubling me a great deal, bleeding, etc., what would you do for them?" and we, without making an examination, would foolishly recommend some ointment or other. I will venture to say that all of us, some time during our career, have done this very thing, but I hope that in the light of our present knowledge, and as we realize more and more the seriousness of the great mortality from cancer, we will never again be guilty, but insist upon a thorough examination. While bleeding from the rectum is usually due to hemorrhoids, still it may be an early symptom of cancer, and we certainly cannot make the diagnosis unless we make a thorough examination.

In cancer of the lip, tongue, mouth and skin the most common cause is chronic irritation, and if we will carefully give our attention to the source of the irritation and its removal, we will have taken a long step in advance toward reducing the mortality from cancer. In the above named regions we can see and inspect the nature of the lesion, and there is little excuse for us in failing to suspect the possibility of cancer. If there appears on the tongue or lips a small lesion such as a burn, fissure, ulceration or leukoplakia and it does not readily yield to treatment, then look out for cancer and so consider it until it is proved benign. At once remove all sources of irritation, such as poor dental plates and teeth, also bear in mind that excessive smoking may produce a chronic irritation and eventually lead to cancer. Leukoplakia is a frequent precancerous condition and should always be carefully watched, and if it shows any signs of a papillomatous growth or ulceration, should be immediately removed.

Warts, moles and lumps appearing in the skin should be carefully watched, for, while most of them are unimportant, those which change their size, shape or appearance in any way should be removed, for there

is a strong probability of their becoming cancerous. Personally, I believe that all pigmented moles raised above the level of the surrounding skin should be removed.

I could go on for some time talking about cancerous and precancerous lesions in various parts of the body, but it would only be a repetition of what I have already said, and in closing I will ask you to remember and also endeavor to impress upon the laity at every opportunity the following facts:

The majority of cancers, if taken in the beginning, are curable.

Practically the only cure for cancer is an early surgical operation.

All benign lesions which do not immediately yield to treatment should be removed.

All patients should be thoroughly examined, and if we are in doubt as to the nature of the lesion, request a consultation.

If we constantly bear in mind the above facts and govern ourselves accordingly, we can most assuredly say that the mortality from cancer will be greatly reduced.

THE PRESIDENT: Gentlemen, the discussion of this most important paper is open to you.

DR. JOHN F. THOMPSON: Mr. President, I am very glad to hear Dr. Spear's very clear disquisition on cancer, although his paper says no word to us of our duty to our patients and to the public in general as to the dissemination of knowledge about cancer. Now the question of the lessening of the mortality of cancer, of course, depends on three main subjects. First, the etiology. In order to make the greatest advance in the cure of cancer, it is necessary that we should know what the cause of it is. We know in the most indefinite way of certain predisposing causes—irritation as the doctor says—local irritation—furnishing soil, perhaps, for the implantation of the disease. We do not, however, know, although the investigation has been very definite and very extensive in all countries, what is the primary cause. Discovering the primary cause undoubtedly will, or probably will, give us the most advanced guide toward lessening the mortality from this disease.

The second of the subjects is the diagnosis, and on the diagnosis, at the present time, rests our only hope for the successful treatment of the disease. Now the doctor has outlined the matter of diagnosis as understood at the present time, but we all have to admit that in certain cases where cancer has early developed the diagnosis is most obscure. Cancer in the abdominal cavity, in the vast majority of cases no diagnosis is made until there is a palpable tumor, and the presence of that palpable tumor is the death-warrant of the patient in ninety-nine per cent. of all cases, and perhaps more. In the same way, cancer of the uterus, cancer of the cervix, of the canal, a clear or fairly clear diagnosis of cancer in a great majority of cases is only made when the disease is in the advanced stage. That leads us to think of measures that may be taken to help us in making the diagnosis. In the incipient cases, it seems to me there are only two ways to proceed. If it looks suspicious, a radical operation; or, if not a

radical operation, the removal of a section of the so-called surface by erosion, or some suspicious granulation on the surface, for microscopical examination. Now in saying that I have in mind what I half believe is the truth. The doctor has spoken of taking a section of a malignant tumor from the breast for the purpose of microscopical examination. That was very finely done, and perhaps you will recall that an instrument was devised by one of the Boston surgeons for the removal of sections of growth from the breast and submission to microscopical examination and diagnosis, and a large series of cases were enumerated in which by various methods sections were removed from the breast for examination prior to operation. It is a matter of reliable statistics that in every case of cancer of the breast where a section was removed and operation not done at once—complete radical operation—the patient died of cancer, even though the operation for removal of the breast was done within five days of the time of removal of the section for microscopic examination. That is definite enough, because it is based on the observations of two of the best men on cancer in the country. The same thing may apply to cancer of the cervix. It is not impossible that taking a section out of the uterine cervix for examination may lead to the dissemination of the disease by blood flow or lymphatics or by continuity of surface to the surrounding organs. At the present time, however, it remains our only and best way, and it seems to me that it is better to take the chances in these cases rather than to do a radical operation, which, even under the best conditions, and in the hands of the best operators, are subject to a high mortality; that it is better to take a section, which may be examined and in fifteen minutes an almost sure diagnosis made, and the operation proceeded with.

Now in cancer of the uterus and cancer of the breast, women do not come as a rule, for operation until the disease is pretty plainly evident, and they come in all stages of the disease. That will always be. So long as human intelligence is what it is and the means of self-diagnosis by women is what it is, there will always be a majority of cases which are inoperable. The question will then be put up to the doctor to discriminate between the cases which are operable and those which are inoperable. My own feeling is that we had better err on the safe side; that many of the cases which we are inclined to believe at first to be inoperable may be subjected to operation with the hope of ultimate cure of the disease. Now this occurs in the experience of every surgeon. He is surprised to find either a long period of delay in the recurrence of the disease, or failure to recur, in cases which he deemed inoperable at the time the operation was done. I believe we should err on that side.

Now as to cancer of the uterus: You will recall that those people whose name cannot be mentioned with any feeling of respect at the present time—the Germans—have the best record in the world for cancer of the uterus and decreasing the mortality therefrom. Now that depends on two things. The German women are better informed, for the German propaganda is extended to them and they avail themselves, especially the poorer people, of the advantages of the clinic and the disease is diagnosed in its earlier stages, with the result, of course, that their surgeons are more successful than the Americans. The surgeons thus see them earlier and the disease is combatted in a radical way. The best statistics which have ever been given for cancer of the uterus are those furnished by the Germans and by Potter in Chicago and Van Wertem's operation for radical removal. So far as I know, that operation has not been done in the State of Maine. We do a hysterectomy, which, for men outside of places

where there is a large amount of work, is likely to be a better method. We get some percentage of radical cures, though not large. We do not get the large number of immediate mortality which is obtained by those using Van Wertem. I am not prepared to state the figures as to the value of lessening the mortality by Van Wertem over the ordinary operation, but it is overwhelmingly in favor of the radical operation, which, as you know, strips up the peritoneum, cleans up the uterus, and endeavors to remove all the glands in the whole gland-bearing area. But if operation is done in these cases, it must be done as completely as is in the power of the operator, and that means, it seems to me, an abdominal operation. I do not believe, as the result of a good many years of operating, here and in other places, that the operation for cancer of the uterus can be done through the vagina with as good prospect of success as where a thorough abdominal operation is done. The same is true also with reference to cancer of the breast. I believe in the investigation of every breast tumor and the proper radical operation applicable to every breast tumor in women over thirty-five years of age, and I think that with this we will accomplish more than in any other way. We know that in cancer of the breast which has arrived at the stage where it is fairly known to the woman and pretty plainly known to the doctor, the number of cases where they are saved by operation is very small; yet it is the thing to do because we now know of no other method except radical operation to cure the disease. (Applause.)

DR. POWELL: Mr. President, one thing in this matter of cancer I think has not been touched upon, and that is the relation of the X-ray in the treatment of post-operative cancers. I do not know just what the opinion is generally with reference to the use of the X-ray in this way, but there was a time when the X-ray was considered a cure-all, and we have all seen the remarkable work that it has done for superficial cancers. Then men came to feel that it was not a cure-all, and that the operation, as has already been well said, can always be performed; but the X-ray was used as a preventive against recurrence. The X-ray was perhaps more used several years ago than now, and in what cases I have personally seen where the X-ray has been used after the operation, it has seemed to me not only a matter of wisdom, but rather a matter of necessity if the proportion of recurrences was to be lessened. This matter is especially brought to my mind this morning because I have just learned that an operation for cancer of the breast, done five years ago in a magnificent manner by one of the Portland men, and which was treated subsequently with the X-ray, has never shown any recurrence in any way, shape or manner until very recently, when, I understand, or was told last evening, that there are nodules appearing at the seat of the operation. Now there has been no X-ray used during the past two years, but up to two years ago this woman was given at intervals of three months rather an intensive treatment, and I really would like to know the judgment of men who have had experience on that line as to what extent the X-ray has been a help against recurrences. I know a great deal of harm may be done by incorrect exposure, but with the exposures that have been used during the last two years I personally believe it to be a very valuable adjunct to the treatment of cancer, and especially post-operative.

DR. SWASEY: Mr. President, the remarks of the last gentleman, as well as those of the reader of the paper, bring to mind a case which I saw—a friend of mine in one of the suburbs of Boston—three years ago, a woman well along in

the fifties, who discovered a lump in her breast and had it removed by the local physician. It was sent to Boston and declared to be malignant. I then persuaded her to go into the hands of one of the leading surgeons in Boston, and the interesting point to me was that he regretted that any incision had been made to remove the lump; that it had a great tendency to disseminate the disease; but the operation was done within a week or ten days, a fine operation and very radical. Following that I asked the surgeon if he would advise X-ray treatment, as I felt that this might be a help to prevent recurrence. He encouraged the use of it and it was used quite intensively for quite a number of weeks. That was three years ago and there has been no recurrence of the disease. It is an interesting point to know whether, following the primary operation, there would have been a return of malignancy had not the X-ray been used. Of course it may never have come back; at any rate there has been no recurrence as yet.

DR. BRYANT: Along the lines of Dr. Powell, I am not a surgeon, but as a diagnostician I have a great opportunity to see a great many cases of cancer of the breast and cancer of the uterus. There is one subject not touched upon especially, and that is the use of radium in cancer of the uterus. I believe that in practically inoperable cases of cancer of the cervix—which I think practically all recur even with a radical operation—you can hold out hope to your patient through the use of radium as carried on by the Memorial Hospital in New York. I have in mind three cases, one a case of inoperable cancer of the cervix, in which a specimen was removed and sent to Boston, with a positive diagnosis of carcinoma. She went to New York to the Memorial and she had two or three massive doses of radium. She goes, I believe, once a year at the present time, and so far as I can see, she is in as good health as she has been in the last five years. The attending surgeon says he can feel absolutely no infiltration of the uterus. A year or so after that I was called on to see a patient, and I found a case of cancer of the uterus—hemorrhage, infiltration into the walls of the vagina, the whole uterus tied down and infiltrated out into the broad ligament. I at once called a consultation and we both decided it absolutely useless to attempt any operation, but knowing of this other case, I told him about the Memorial. I said, "I don't believe it will do you any good, but go up; it is the only hope I can hold out to you." This was three years ago. The patient went up and as far as I can see at the present time, she has absolutely no evidence of infiltration, is absolutely well, the thing is arrested, but whether or not a cure we do not know. All we know is that three years have elapsed.

One year ago I was called in consultation in another case where there had been an operation, and following the operation a quick and rapid growth in the sac behind the uterus, with infiltration of the uterus and massing together of the intestines. It was an inoperable case and I said there was nothing more to do. I said, "I cannot hold out any hope, but go to the Memorial and try radium." This was one year ago, and whether or not the thing was malignant I cannot say; nothing was removed. The woman, however, came into my office within a month. She has put on forty pounds of flesh, red cheeks, a freely movable uterus, and, so far as I can see, no evidence of disease. She had one massive dose of radium and that was all.

Another case! A patient of mine went to New York for an operation, a woman along towards eighty years of age, with a rapidly growing carcinoma of one breast. She went to the Presbyterian Hospital, and before operation she had one month's treatment of the X-ray—what they call the blocking treatment—

and then the thing was removed under local anesthesia. The whole breast and glands and everything were cleaned out. She came back and made a rapid recovery, but with the instruction from the Memorial, where she was sent, that once in three months she was to return for the blocking treatment of the X-ray over the area and around the outside edges, and she has just gone there at the present time. That seems to be the prevailing treatment in New York, especially at the Memorial Hospital, that there shall be in cancer of the breast, and such cases, an X-ray treatment before operation and after operation.

As for the matter of removing specimens for examination, I think, as Dr. Thompson has said, that by the best surgeons that is absolutely tabooed. When you make a clean cut into a cancer of any kind, you open up your avenues by which you get your dissemination, and the only way if you are going to take specimens is to take them at the time of the operation, and, if you find it is carcinoma, make your radical operation. Make a clean sweep by a radical operation if you are at all suspicious. You may remove a good many bunches from breasts which seem to be pretty good breasts, but you are pretty sure, if you take it in time, to cure your patient.

PRESIDENT COOMBS: I wish to call your attention to the work of the Society for the Prevention of Cancers, which has a representative in this state headed by the State Board of Health. They furnish speakers to talk to lay audiences on this problem. I cannot let this opportunity go by without registering two cases, one of seemingly fatal cancer of the cervix extending to the upper vaginal wall. The operation was done sixteen years ago in September and there has been no recurrence. Another similar case was done four years ago in Rockland, and there has been no recurrence in that case. This paper is too important to let pass without further discussion.

DR. BENNETT: Mr. President, I should like to inquire whether any of the physicians present have had experience in treating cancer of the rectum with radium? I found a case very recently of that kind which seems to be inoperable and I have been advised that radium might be of use. I would be very glad to know if any light can be thrown upon this question.

THE PRESIDENT: Has anyone had experience in the use of radium in cancer of the rectum?

DR. BRYANT: I should send the case to the Memorial or Huntington and let them decide it.

DR. WAKEFIELD: Mr. President, I have had no particular experience with radium in cancer of the rectum. When radium was first talked about, several years ago, I was very skeptical about its use, and thought it probably a passing fad, but having been associated with Dr. Robert Abbey, of New York, during the summer months, and having seen some of the wonderful things he has done, I am thoroughly converted to the use of radium in selective cases. He has treated quite a number of cases of cancer for me and other men on Mount Desert Island; in fact, the man is so busy with malignant cases that he does nothing else now in the summer months. He has had wonderful success and he probably has the finest collection of radium of any man in America. But I think he has had the most brilliant success in cancers of the face—lip, eye, nose—and after one or two treatments of radium it is remarkable how these will heal perfectly smooth, to such an extent that you would not think any disease had ever occurred. He has

treated other cases for me, and for other men on Mount Desert Island, with remarkable results, and I want to say that I have been won over to the use of radium, especially in operable cases, where he seems to get remarkable results. He is treating a friend of mine now who has inoperable cancer of the rectum. I do not know what the result will be, but I have understood that the man is gaining, and Dr. Abbey has told him that he expects at least to arrest the growth absolutely and give him a few years of life, if not an entire cure.

DR. WEBBER: Mr. President, I am in the same position as the previous speaker. I have had no personal experience with radium, but I have a case that I know of that has been treated by Dr. Kelly, of Baltimore—a case of inoperable carcinoma—and as far as I am able to judge, the woman is practically cured at the present time. Dr. Kelly is a pioneer in the use of radium and one of the big men in that line, and it seems to me that if he would take it up and use it, there must be some good in the remedy. This case, certainly, has shown striking improvement. She had a very advanced case and no surgeon dared to tackle it. She is much better at the present time. It is really too recent to judge whether or not the cure will be permanent, but I feel that if I had another patient with cancer, I should certainly advise the use of radium, provided the patient could possibly afford the expense of it.

Another thing I want to speak about is an idea that I picked up while at Camp Devens concerning the treatment of warts. Our specialist in skin diseases at the camp, Major Jayne, a man from Virginia, treated warts by exposing them to sunlight through a glass, the same as children focus the sun's rays to burn leaves and wood. He focused the sunlight on the wart, exposing it for three minutes. This exposure to the sunlight, focusing a magnifying glass on the wart, was continued for about a week or ten days according to the size of the wart, causing it to completely disappear without any pain or discomfort to the patient. Such a simple procedure any of us can practically install, and I thought I would spread the knowledge. He focused the lens so that a small ray of light struck on the wart. It does not want to be hot enough to burn it. When you think it is about ready to burn, take it away.

THE PRESIDENT: Is there any further discussion on the paper? If not, will Dr. Spear close?

DR. SPEAR: Gentlemen, I have been very much interested in the discussion the paper has brought forth, but it seems to me that we have drawn away a little from the object of the paper. My purpose was not to take up the treatment of cancer, but rather to bring the attention of the medical profession, and through them to the laity, that in the light of our present knowledge we have only one means to hold out a hope of cure, and that is by early diagnosis and operation.

When you talk about radium, X-ray, and so forth, I think there are but very few men in the country today who know anything about it. While I agree with most everything that Dr. Thompson and Dr. Bryant said, I must differ with them as to the advisability of depending upon pathological examination at the time of operation, as I have seen grave mistakes made by the pathologist in using the microtome. In making the examination they do not get the section which contains the cancer cells, and the report is benign. Consequently, the cancer reappears later, too late for much hope of a cure. We know that the cancer cells are disseminated through the body by the way of the lymphatics, and this occurs when we cut into the growth.

As to use of the X-ray after operation, I have always thought that was a good thing, although I know but little about it. I was interested to see what they were doing at the Huntington Hospital in Boston in that line; in fact, I had a patient who had a cancer of the orbit removed, including the eye, the skin of the forehead and so on, which seemed to be a very favorable case for X-ray treatment. They said to me there, "Do not use the X-ray after operation unless there is some kind of recurrence." At the present time we do not know how to handle the X-ray. We do not know the dosage, and so forth, and very often we will hasten the recurrence of the growth rather than retard it. Until we can get the dosage down to a standard, we are not advising it. There are only one or two men in this country who know anything about it or how to handle it.

DR. THOMPSON: Mr. President, may I make a correction? I think the record will show that I did not advise as a matter of procedure to remove a section of the breast for examination.

DR. SPEAR: I understood you so.

DR. THOMPSON: I said there were cases in which it might be done. I am opposed to any of the operations which do not include even the removal of the tumors of the breast. The least operation which I would approve is the removal of the whole breast.

Necrology.

EDWARD COWLES,

1832-1919.

Dr. Edward Cowles, an honorary member of our association, is dead at Plymouth, Mass., at the advanced age of eighty-two years.

After graduating with the highest honors at Dartmouth in 1859, he studied medicine, chiefly at the medical school connected with his college, and obtained there his degree of M. D. in 1863. He figured very prominently in the medical service of the nation during the Civil War, and continuing in the army he was for some time stationed at Fort Preble in Portland Harbor. Whilst there he was very intimate with many Portland physicians, and owing to the extreme interest which he showed in everything medical, he was elected, as has been said, an honorary member of our association about 1866. In 1897 he returned to Portland and delivered before us the annual oration, "On the Relation of Mental Diseases to General Medicine."

After resigning from the army about 1870, he served as superintendent of the Boston City Hospital, and later on of the McLean Hospital for the insane in Massachusetts. He also figured very prominently in many law trials as an expert alienist. He was, moreover, in high renown as a lecturer on psychiatry at the medical schools connected with Dartmouth, Harvard and Clark Universities.

Although now forgotten entirely by the younger members of our profession, Dr. Cowles was for many years, from 1870 onward, a shining light in American neurology and psychiatry, a member of many medical societies, and a man and writer and speaker on medical topics of rare force of character.

J. A. S.

SOMERSET COUNTY MEDICAL SOCIETY.

This society had its usual semi-annual meeting at Smithfield, on Thursday, August 7th, and entertained as guests the members of the Kennebec and Franklin County societies. Forty-two physicians were present and various clinical cases were mentioned, and discussed.

In the unavoidable absence of the President, Dr. Sawyer, Dr. H. W. Smith officiated as presiding officer. The meeting was a success from every point of view.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

PRESIDENT'S ADDRESS.

Those of us who were in close touch with the work of our retiring president during the past year can fully appreciate the seriousness with which he has placed before the members the various suggestions offered in his annual address. It should be remembered that his time in office was a trying one, owing to many of the men being in the service, the shortage of physicians in this community, and his untiring efforts to attend various county meetings, co-operate with the state health department and working on legislative matters. His earnest suggestion that the delegate to the American Medical Association be elected for a term of two years, and subject to re-election, was promptly acted upon by the Association, and will doubtless prove a valuable aid in the future work.

His comments on the legislative work of the last session are interesting, as we believe every member of the Association should be interested in these legislative problems affecting the public health. Through his earnest efforts a committee has been appointed with power to arrange constructive legislation along lines set forth in his address, and we sincerely hope that the next session of the legislature will find more earnest support from the rank and file of the professional men. It would seem that the time has come when we would better submerge our private opinions, and study conditions in other states with a view of adopting some plan which will eliminate future legislative work on the part of the profession to protect the public health.

STATE MEETING.

The sixty-sixth Annual Meeting of the Maine Medical Association has passed into history, and much credit is due the committee in its arranging for an interesting and instructive program.

Three important topics were brought into the foreground, namely, the laws governing venereal disease, the medical examiner service, and the question of social service. All of these subjects were handled by men thoroughly fitted to discuss them. The July issue contains the transactions of this session, and it is with pleasure that we point to the work of Dr. Whittier and his committee, which has proven of great value to the people of Maine, and its influence has reached considerably beyond.

The report of the Association by the Secretary shows it to be in a flourishing condition, and by another year it should be in a position where it could seriously consider the adoption of a medical defense plan, similar to that now in operation in the majority of states and proving to be one of the biggest factors in preventing malpractice suits.

The reports from the different councilors have indicated a laxity on the part of some of the county societies in holding their regular meetings for one reason or another, the war and the epidemic being the two principal reasons. As fall advances there can seem to be no reason why the county societies should not become active again and take on a new lease of life, as there is a great deal of work to be done, while the association and good fellowship attending the meetings are well worth anyone's while. A few years ago the budget system was adopted in estimating the expenses and making the appropriations for the year and this has proven very valuable, inasmuch as it curtails the appropriations for the current year to the normal limits.

Much constructive work was planned at this session, and is in the hands of committees, to be carried on and reported at the next annual meeting. Our new president, Dr. Mason, of Calais, who has served long and faithfully as secretary of the Washington County Association, and assisted in making it one of the strongest county societies in the state, will surely do his part in assisting every county society to carry on their work, and we can assure the county secretaries of his hearty co-operation. We should look forward to a large and interesting meeting in Augusta next year, and plan our vacations so as to be there on time.

AN EAR HINT TO MEDICAL EXAMINERS OF RECRUITS

Shuter, in the *Medical Journal* of Australia for September, has examined three hundred instances of war injuries of the ears and detailed them fully in his paper. Experience has shown him that it is an economic and military mistake to pass for active service any who have ever had any suppuration from the middle ear, even if cured with resultant good hearing, or those in whom there is a perforation of the drum-head, for, owing to the hardships of war, camp life, and especially

of trench fighting, cases of suppuration from the middle ear that had long been quiescent break forth into fresh and dangerous vigor. The soldiers then become useless for service, and they occupy hospital beds which are urgently demanded for more serious cases. The author adds that rupture of the drum-head from explosions is often observed in war, but that it generally heals over by first intention. Such is his experience, which, however, differs greatly from that of many other military surgeons, who had discovered after such explosive ruptures severe and obstinate otitis media suppurativa, with extensive destruction of the drum-head and loss of hearing.

From this annotation we discover that any recruit with a perforation of the drum-head, with even perfect hearing, ought not to be accepted for war service.

SCOTOMATA IN EYES OF AVIATORS.

Aviators, aviator watchers, and men employed as aviator machinists and crews are developing a curious condition of vision characterized as a central ring scotoma for white. This ring embraces the centre of vision at a distance of about 30 degrees. Although generally circular, it sometimes is partial, and then only sickle shaped. Sometimes the sickle is above, but generally to the temporal side. The scotoma does not generally interfere with central vision, but produces a shadow, a disagreeable sensation around or to the side of objects, and to some extent interferes with accurate observation of objects below the machine. Some of these scotomata have been watched for more than a month, and show but little change, if aviation is continued steadily. The cause is due to dazzling by light reflected from the mists and clouds of the atmosphere. The scotoma does not show itself in beginners in aviation, but only after some months of work, and in the darker seasons of the year it is less observed than during the brighter seasons.

A MEDICAL UNION IN GREAT BRITAIN.

The physicians of the United Kingdom are organizing rapidly, and planning a closed shop of unionism precisely as labor has done for the past few years. At the fifth annual convention of the Medico-Political Union, members threw aside their former opposition and came out boldly and bodily for unionism. Resolutions were passed favoring the organization of the entire profession on a trade union basis, and calling on the government to set up a new imperial office under the Minister of Health.

It is high time that the socialism of the medical profession in the United Kingdom, as finally brought about by health insurance, was put an end to, properly and in good form. This can be best done by a union as here suggested. Details of union formation shall be printed from time to time in the JOURNAL as received from abroad. Such a plan will take time to mature and to mould into shape, but it is high time that it should be begun overseas, and that health insurance in America was opposed root and branch.—J. A. S.

INFLUENZA EPIDEMIC QUESTIONS AND ANSWERS.

1.

Q. Will the epidemic again appear?

A. The epidemic will recur, for medical history shows that we have had a series of influenza or grippe epidemics, the last of which proved to be of the most virulent type. There immediately occur to me those of 1867 and of 1889 to 1895. The Metropolitan Life has issued some very definite figures on this latter epidemic covering millions of policy holders, which show an average increased mortality for the five years following of 40% above the normal death rate. Any estimate of economic loss should include the 40% increased mortality that, in all likelihood, will similarly occur in the next four or five years.

2.

Q. Is its origin fairly well known? If not, the likelihood of definite information by research.

A. Much private research has been carried on, but its origin and spread is still undetermined. This must be collected and further stimulated, for only through careful research is there any likelihood of definite information.

3.

Q. What success in the discovery of an antitoxin?

A. The possibility of the discovery of a real antitoxin for influenza is wholly dependent upon the discovery of the actual germ, causing the disease.

4.

Q. The possibility of collecting necessary information and its distribution among the people to reduce the dangers of its spread and increase the chances of recovery?

A. I need but cite two of many similar researches, successfully undertaken, that have practically eliminated the dangers of the spread of disease, to wit, malaria and typhoid. Except for our knowledge of typhoid, the armies of Europe would have been decimated by this disease alone.

5.

Q. The generally bad after effects of the disease?

A. The generally bad after effects of the disease are unfortunately too well known by the profession. The Red Cross Chapter in Cincinnati is expending perhaps \$200,000 in an effort to examine physically every person that has suffered with influenza; to discover

the pathological conditions—bad hearts, bad kidneys and lungs—resulting from this epidemic, and relieving the poverty and chronic invalidism that accompanies it.

6.

Q. The economic loss to the country of the epidemic?

A. The economic loss can hardly be estimated. The 500,000 deaths alone represent \$2,500,000,000 economic loss. Economists all agree to the fact that \$5,000 is the minimum social and economic value of a human life. It is safe to say that 10,000,000 people had the disease and that they lost 150,000,000 working days. At a minimum combined loss of wage and production of \$7.00 per day, there has been another \$1,000,000,000 of economic loss to the country. In other words, conservatively speaking, we had between \$3,000,000,000 and \$4,000,000,000 loss in this last epidemic.

RESOLUTIONS.

WHEREAS, the present influenza epidemic caused approximately 500,000 deaths in the United States, and

WHEREAS, a large proportion of these deaths were produced by pneumonia and other complications, and

WHEREAS, influenza, pneumonia, and allied diseases now cause approximately one-tenth of all the deaths in the United States, and

WHEREAS, medical science is not yet in possession of complete data as to the cause, modes of transmission, prevention, and cure of this disease and its complications, and

WHEREAS, the possession of this knowledge is of grave social and economic concern to the nation:

THEREFORE, *Be It Resolved*, That it is the sense of the members of the section on Industrial Medicine and Surgery of the American Medical Association, here assembled to discuss influenza, that Congress should and is hereby urged to appropriate not less than \$1,500,000 to be used under the direction of the U. S. Public Health Service for the investigation of the causes, modes of transmission, prevention and cure of influenza, pneumonia, and allied diseases, this sum to be made available to July 1, 1922.

Transmitted by order of the session, held in Atlantic City, June 13, 1919.

DR. OTTO P. GEIER,

*Secretary, Miscellaneous Topics, Section on
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County News and Notes.

AROOSTOOK.

AROOSTOOK COUNTY MEDICAL SOCIETY.

The annual meeting of this society was held at Crescent Park, Houlton, June 26, with the President, Dr. H. L. Dobson, in the chair. There were twenty-six members present, fully 20% of the membership.

The records of the previous meeting were read and approved, and the Treasurer's report accepted.

The following officers were chosen for the ensuing year: Dr. F. W. Mitchell, of Houlton, President; Dr. E. H. Doble, Presque Isle, Vice-President; Dr. F. E. Bennett, Presque Isle, Secretary and Treasurer.

Dr. F. W. Mitchell was elected as delegate to the Maine Medical Association for two years, and Dr. P. E. Gilbert, Censor.

It was voted to remit dues to Drs. Floyd, Sawyer, Thomas, Bates, Potter, Gregory and Damon for time spent in army service.

A letter of sympathy was voted to be sent to Dr. F. O. Hill, undergoing an operation in a hospital.

The Board of Censors reported favorably on the admission of Dr. C. H. Chandler and he was elected.

Three members were chosen to act with the President and Secretary to prepare a program for the next meeting.

The matter of physicians making insurance examinations for less than the recognized fee, as well as for doing contract work, was discussed at great length, and it was voted that the Censors interview members reported as making examinations below the recognized fee and doing contract practice and have them show grounds why they should not be suspended from membership. Furthermore, if such offending members failed to report to the Board on due notice, they should be deemed guilty and be forthwith dropped from the society.

Applications for membership were received from Dr. Small, of Fort Fairfield, formerly of Waldo County, and Dr. W. A. McDougall, of Westfield.

A committee was appointed to draw up resolutions to the widows of Dr. Porter, of Caribou, and Dr. Walker, of Houlton, who died during the past year.

After an excellent shore dinner the afternoon session began in the open air, with a paper by Dr. H. W. Johnson, of Wytopitlock, an "In-

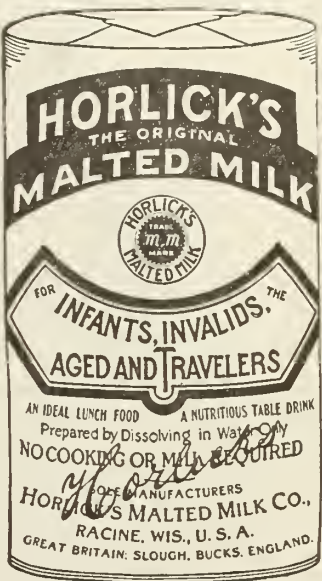
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fection from the Teeth,” which was discussed at length in relation to the eye, ear, rheumatism and diabetes, and the absurdity of capping, and the use of X-rays.

Dr. Gregory, of Caribou, then spoke on “Fractures of the Long Bones in Military Practice,” showing how wire splints are adjusted, and how the patient can then be moved. He also showed its application as a means of traction and retention of the fracture.

A paper was read by Dr. J. L. Johnson, of Mars Hill.

The President, Dr. Dobson, read a valuable anatomical and surgical paper entitled, “A Plea for Early Operation in Middle Ear Diseases,” which was widely discussed by several of the members.

Dr. Addison S. Thayer, of Portland, followed with a timely talk on “Our Successors,” or the general state of medicine at present, with many practical suggestions.

Dr. Spalding spoke on his favorite topics of medical advance, meaning our medical examiners and their lack of opportunities for post mortem examinations; compulsory physical examination of school children in place of the present voluntary system, and mutual medical defense by the members of the association as more effective than mere corporation insurance against mal-practice suits.

Altogether, the meeting, with its good attendance, instructive papers and particularly the bright discussions, was a model for county medical gatherings.

DR. F. E. BENNETT, *Secretary*.

YORK.

YORK COUNTY MEDICAL SOCIETY.

The ninety-seventh quarterly meeting of the York County Medical Society was held at the Marshall House, York Harbor, Friday, June 27th. This new structure is one of the best and most richly appointed hotels on the entire Atlantic coast.

In the absence of the President, Dr. F. W. Smith, the Vice President called the meeting to order at 12.30 P. M. Dr. Smith reported as a delegate to the annual meeting of the Maine Medical Association.

Reports were made relative to the condition of two of our members who have been ill for several months, Dr. J. L. M. Willis, of Eliot, and Dr. C. W. Pillsbury, of Saco.

Drs. W. W. Varrell, F. W. Smith and E. C. Cook reported an interesting case of carcinoma of the abdominal viscera.

Major C. F. Kendall described the successful treatment of influenza epidemics in France by using a 25 per cent. solution of argyrol spray in the nose and throat. This, with isolation of patients, stopped an epidemic within five days.

An excellent dinner was enjoyed in the spacious and beautiful dining room of the Marshall House, from 1.30 to 2.30.

Major Roland B. Moore, of Portland, was a guest of the society, and he gave a most entertaining and vivid description of some of his unique and exciting experiences while in the U. S. military service in France and Germany. Major Kendall, of Biddeford, spoke of his experiences in overseas service, and Dr. D. W. Wentworth, of Sanford, described his duties as a medical officer at Camp Dix. All these remarks were instructive and enjoyed greatly by all present. A vote of thanks was given Dr. Moore.

Those present: Dr. R. B. Moore, Mrs. William S. Moore, Portland; Dr. and Mrs. F. W. Smith, Dr. and Mrs. E. C. Cook, York Village; Dr. and Mrs. W. W. Varrell, York Harbor; Dr. and Mrs. H. L. Prescott, Kennebunkport; Dr. and Mrs. C. F. Kendall, Biddeford; Dr. and Mrs. R. L. Maybury, Miss Annie Dennett, Saco; Dr. and Mrs. D. W. Wentworth, Miss Jaggar, Sanford; Dr. J. W. Gordon, Ogunquit; A. L. Jones, Old Orchard.

Fraudulent "Cures" For Venereal Diseases Seized.

Federal Inspectors in Clean-Up Campaign on Falsely Labeled Compounds.

WASHINGTON, D. C.

By order of the federal courts more than 450 seizures have been made recently in different parts of the United States of so-called cures for venereal diseases. They were made on information furnished by officials of the United States Department of Agriculture through its Bureau of Chemistry. A campaign to end the false labeling of such preparations is being conducted by the officials charged with enforcing the Federal Food and Drugs Act.

The goods seized include a great variety of compounds. Some of the labels bear the claim of the manufacturer that the contents are sure cures for venereal diseases. Some even contain statements that cures will be effected within definite periods, varying from three days to a few weeks. In others indirect statements, suggestive names or deceptive devices are craftily used to make it appear that the use of the preparation will be followed by a cure of the disease.

In all the seizure actions the government alleged the preparations to be falsely and fraudulently labeled, because the ingredients could not produce the results claimed on the labels.

The officials state that such preparations are sold largely because of plausible but false claims regarding their curative effect. Many sufferers with dangerous contagious venereal diseases are led to believe that cures



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will be effected by these preparations, and adequate treatment under competent medical supervision is neglected until permanent injury to health and even danger to life has resulted. Thus is created one of the greatest obstacles to the proper control and eradication by health officials of venereal diseases. In many instances had such sufferers secured competent advice, early and complete cures might have been effected.

Self-treatment with worthless concoctions causes not only continued suffering but sometimes permanent injury to the unfortunate victims, and makes of them a menace to the public health because of the extreme danger of others contracting the disease from them.

Action under the Federal Food and Drugs Act in reference to venereal disease preparations coming under its jurisdiction and sold under proprietary names is limited by the terms of the act largely to the prevention of false or fraudulent labeling. The act does not prevent the sale of any mixture as medicine, however worthless it may be, if there is directly or indirectly no false or fraudulent labeling. The officials in charge of the enforcement of the act are of the opinion, however, that by causing the elimination of false labeling, upon which the sale of such preparations largely depends, the evils and dangers resulting from their indiscriminate use can be greatly checked, and substantial aid rendered to public health officials.

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York,	A. T. Davis, Springvale,	A. L. Jones, Old Orchard.

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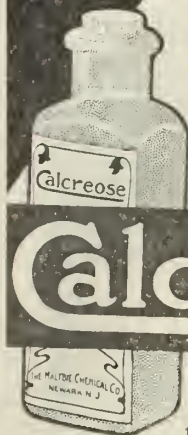
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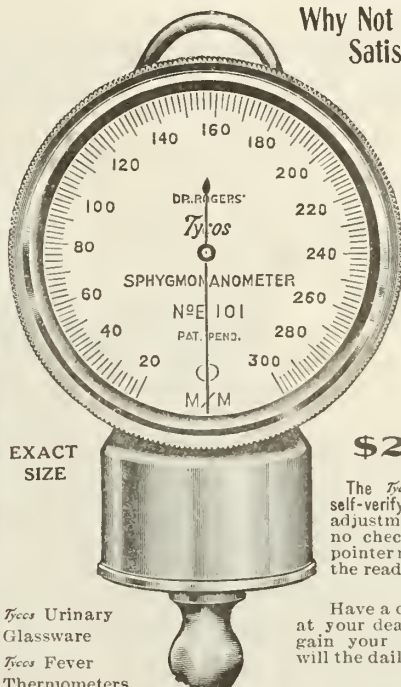
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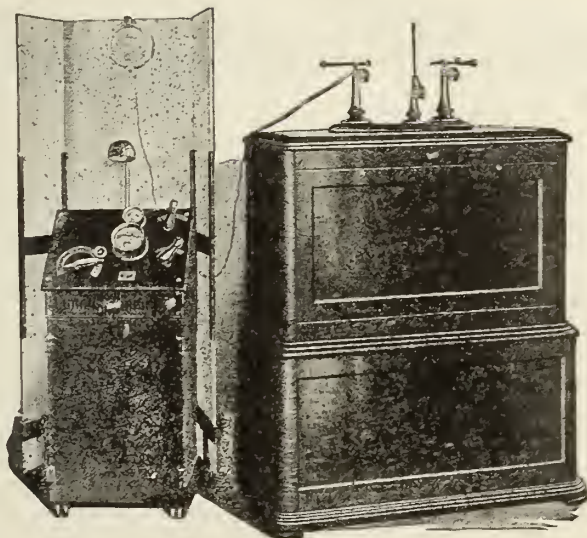
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No. 2

THE DEVELOPMENT AND OPERATION OF OUR BASE HOSPITALS.

By W. E. KERSHNER.

Two years ago, the most of us had, at best, very vague ideas of what a Base Hospital was like, except in the most indistinct sort of way, as one of the activities connected with the medical military establishment. Of the history, tradition and responsibilities of Base Hospital duty, we understood even less.

The history of the development of a co-ordinated Army Medical Service is of comparatively recent date. The Base Hospital is one unit of that co-ordinated service.

Until the middle of the last century, the growth and development of medical organization for armies, had been very slow. In fact, the exact origin, it is impossible to point out; but, it did begin in a humble sort of way, when army commanders hired surgeons of note to accompany their military expeditions and lend whatever aid they could to the wounded. More often than otherwise, these surgeons were without trained assistants and very short of material and supplies to work with. Later, when the numbers of medical men had increased, they and their assistants and supplies were looked upon by the fighting forces as a sort of necessary evil and as a hindrance to rapid operation. Some of the most prominent army commanders of history argued that the space taken up by Medical Departments might better be used for what they considered more useful material. Until comparative recent

date no effort was made by governments or army commanders to conserve the health of the soldier during military operations. During these times there was no such institution as a Military Hospital. The sick and wounded were cared for in houses, huts, and tents, not in any systematic, organized fashion, but wherever and whenever the need arose.

It may be truly said, that until the middle of the last century, no serious thought was given to the wounded soldier, and his recovery was of little concern to anyone. The fact is, that the surgeons of those days followed the army for no other reason than the prestige which the operating experience gave them. And except in isolated instances, the military surgeon of those days left nothing of professional value to succeeding generations.

Up until our own Civil War there was no carefully thought out system in operation to evacuate the wounded, classify them, or return the recovery cases to the ranks. In other words, no system to relieve the mobile armies of the burden of their own sick, and apply definite design to the problem of the sick and maimed soldier.

The technical side of this problem was thought out and working system outlined by Gen. Letterman, who published it for the use of the armies. Gen. Letterman's Ambulance System is the beginning of thorough Army Medical organization. Until this time the valuable work of the medical man with armies had given posterity little of value, because no records were kept in anything like a complete manner and no system in use which compared methods of practice, and from such comparison to develop newer and better methods.

A very incomplete sketch of the past in Army Medical work is necessary to show why the Base Hospital should exist and that the necessity is of recent origin. And that until a system had been adopted to free the forces of their own sick and wounded, a well co-ordinated Medical Service was an impossibility, and a Military Hospital was not a matter of system, but more or less left to chance. At these times dependence was placed on Civil Hospitals when such were at hand.

Now, with a regular organized evacuation of casualties there must be a balanced, convenient and elastic hospital to care for the cases. You will notice I have used the term "elastic" in the description of the type of institution needed. Indeed, our Base Hospitals are elastic, and in this country alone during the last two years, every base Hospital has cared for more than double its rated capacity.

The Crimean War was the first conflict to see definite Military Hospitals on a large scale established for the care of the wounded. These large French and English institutions, situated near Constan-

tinople, broke the ice and demonstrated the possibilities of such institutions. It may also be noted that this war was also the first in which the trained nurse was introduced to Military medicine. Then our own Civil War, with Gen. Letterman's remarkable system developing ability, demonstrated the utility, practicability and absolute necessity of such plans.

The development of Base Hospitals with permanent and accurate keeping of records, with painstaking study of cases, and the records of those investigations have added laurels to America and demonstrated to the world that our forefathers in Medicine were to take their place in the van of medical progress by passing down to succeeding generations the most complete records ever to this day published on medical and surgical aspects of war. That these careful observations of our forefathers in medicine is, and has been appreciated, probably more abroad than at home, I will quote from the eminent Virchow, who expressed his opinion of the medical and surgical history of the Civil War as follows: "It is a critical study, made in a genuinely scientific spirit, with an open mind, sane, practical sense, which informed every department of the American Army Medical Department, and which, with the splendid support of an entire nation, reached the highest point of humanitarian achievement in any great war."

In order to appreciate more fully those words of praise by Virchow, let us point to a few things which stand out in remarkable relief at this time. We have heard and read much during the World War of the so-called "soldier's heart" (Cardiac syndrome, as the English term it, or Neuro-circulatory asthenia, as our Surgeon General wishes it called.) You all are much more familiar with the large amount of investigation and reports in this condition than I am. The investigations along this line by Osler, Lewis and McKensie have been exhaustive, yet they remind us that the very same condition was most accurately described by De Costa during the Civil War. Again, trench nephritis, which was probably new to most of us two years ago, was prevalent enough to demand special investigation during Grant's campaign in 1864. At this time control of venereal disease was instituted. And in the special investigation of the effects of gunshot wounds of the nerves was laid the foundation for that epoch making monogram of 1872 by Mitchell. This investigation and study paved the way for the recent studies on gunshot wounds of the peripheral nerves. Let me assure you that the most wonderful storehouse of information awaits anyone who wishes to consult the Medical and Surgical history of the Civil War.

In the foregoing I have endeavored to show the value of the Base

Hospital to the government as well as to the profession of medicine.

These institutions are permanent organizations and usually are housed in semi-permanent frame structures, which are built upon the pavilion plan. The Base Hospitals of the present day vary only in minor details from those of the Civil War. The arrangement of the several buildings has been changed somewhat. The earlier Base Hospital buildings were so arranged as to form a triangle or quadrangle. At the present time they are arranged in tiers with the administration buildings forming the middle row, and the ward buildings arranged in rows on either side of the administration line. These buildings have been and are still, for the most part, of one story, frame construction. With each ward of 48 beds complete in itself, that is, it contains its own toilet, ward record office, storeroom, dressing room and diet kitchen. The heating of these institutions is either by a central plant or large individual stoves.

During the last two years, two story ward buildings have been added to the single story group, these to hold about 72 patients.

In a Base Hospital of about a thousand beds, we find from 50 to 75 buildings, for the most part joined by long corridors and so spaced from each other as to be safe from fire danger. The personnel of a Base Hospital is a complete administrative unit of itself and accountable to the Surgeon General's office direct. The organization is divided into the administrative service, the medical service, the surgical service, and the laboratory service. To one of those departments all sections belong.

The administrative work is charged with general supervision, and co-ordination of the whole. The medical service, as the name implies, has under its control, and cares for, the strictly medical cases, including herein all the medical specialties, such as nervous and mental diseases, epidemiology, gastro-enterology, skin, etc., which are represented by separate sections. The surgical service is the largest in point of administrative work, as it has supervision of all general and special surgery. The separate section of neuro-surgery, nose and throat, dental surgery, plastic surgery, ophthalmology, genito-urinary surgery, and orthopedics, are under the supervision of the surgical service. Under the laboratory service comes the work of the laboratories, bacteriological and pathological, X-ray, the autopsy rooms, and the care of the dead. Any of the above departments call upon any of the other departments, at any time, when assistance may be needed in the study or care of cases.

The number of medical officers for carrying on the work in one of these institutions varies according to the needs of the service. The Table of Organization of the United States Medical Department allows

about 30 medical officers for each thousand bed capacity, but in actual practice in this country between 50 and 60 medical men have been on duty for each thousand bed capacity.

The Commanding Officer has charge of the whole plant, and under him all departments and sections function, and all are responsible to him. He, with his assistant and adjutants, have immediate charge of the administrative service, which includes the record office, receiving office, property offices, both medical and quartermasters, the sanitary police work and the messing, all of which are represented by an officer who actually supervises the work. Each department head controls the internal policy of his own department and is answerable to the Commanding Officer for the success of his own work and that of the junior officers who are assigned to his department. The ward surgeons, usually junior medical officers, are in charge of the actual ward work, the professional work as well as the care of the sick, and are responsible to the department head to which they may be assigned and are subject to his orders.

The actual nursing is done by the female nurses corps and enlisted men, who when in training show an aptitude for that duty. About 125 nurses are needed to direct the care of the nursing, keep the records and supervise the diet.

From 250 to 300 enlisted men are required in and about a thousand bed hospital. Their duties are many; those suitable are in the wards doing the heavier work in the care of the sick, under the direction of the female nurse. It is surprising how many of these men develop a talent for nursing, and they do it very quickly. Besides the above, from the enlisted men are drawn the non-commissioned officers for each department and ward, the clerks, the property caretakers, the police work and guards, kitchen and mess hall attendants, etc. It may be illuminating to enter a supposed sick man in the hospital, to show the amount of work necessary to keep track of him and give him proper care. Such a man reports to his organization medical officer, who upon examination enters his name, rank, number, and diagnosis, with any other pertinent remarks, upon a card which is sent with the man to the Base Hospital. He is taken to the receiving ward, where he is examined by Medical officers detailed for that special duty only. There, too, a record is made of his name, number, birthplace, nationality, home, age, length of service, with name and address of his nearest relative. Here his clothing is taken, also his property, both personal and government, money and valuables, for which a receipt is given him. A copy of all this is sent to the ward with the man, where he is immediately seen by the ward surgeon, or medical officer of the day. This

officer verifies or otherwise comments on the original diagnosis, which has also been checked up by the receiving officer. Our man is now prescribed for and he will be presented to the chief of service on his round, or if the case be urgent, the chief of service or his assistant will be called immediately. You will see that our man has been examined by three medical officers, beside the chief of service, all of whom are required to record their diagnosis. This patient has been from 20 minutes to two hours getting this far. Further developments in the case will determine whether any of the specialists are to be called by the chief of service. If so, the officer's opinion and finding are written on the progress sheet of the history, as well as all of the laboratory findings, and previous medical history.

The return of our patient, when well, to his company or organization is determined by the chief of service under whose charge he may have been, and is through the receiving ward, where he picks up his property and where his medical and surgical history are completed.

There is no time in the 24 hours when there are no medical officers on duty. The medical officer of the day, and the emergency officer of each department, are always available for the treatment of the sick.

Of the many activities participated in by the medical officers, the most important are the bi- or tri-weekly conferences. These, in fact, are clinics at which interesting and unusual cases are shown and discussed. Papers are presented on timely subjects and these are discussed. Probably no activity of a Base Hospital staff is of more value to the medical man, to the patient, or to the government, than these clinics. Open and free discussion is encouraged and entered into; the exchange of ideas is illuminating.

The writer, as chief of the ophthalmic service in one or another Base Hospital during practically all of his service, was in a favorable position to judge the medical work of the American physician as a body. And I want to say to you emphatically that the results were excellent. The devotion to duty, the almost careless disregard of their own health or feelings during such periods as the influenza epidemic, and the sympathetic regard in which they held each of their patients, was nothing short of remarkable. I wish, further, to state that of all the agencies engaged in helping to win the war, none were more efficient than the medical men. Physicians from all walks of life and experience found their opportunity and were on an equal footing. The self-reliant, accurate power of observation and resourcefulness of the clinician were needed and appreciated by the highly trained laboratory worker. In fact, the difference in training and experience of officers

from different localities seemed to dove-tail to a nicety, and working together produced most excellent results.

It was just such devotion to duty, careful investigative minds, and accurate recording of data, which made the medical and surgical history of the Civil War a standard for all time, by which such records will be compared.

It is just such abandon of self-interest, and intense application to problems medical, which will make the medical history of this World War compare favorably with that of the Civil War, and also equal any like record which may be the work of any of our allies or enemies.

In the space allotted to this paper it is impossible to present a word picture accurately and in detail of all Base Hospital activities. I have hoped to show something of the place of importance such an institution holds in an army medical organization and of the value the accurate records are to medicine as a profession, the physician as an individual, and to the nation.

WEDNESDAY AFTERNOON, JUNE 18, 1919.

THE PRESIDENT: The paper is open for discussion. There are a number of men here who have been in the service who know from practical experience the workings of base hospitals, and whose personal observations will be of benefit to us. We will be very glad indeed to hear their point of view on this subject.

DR. CUMMINGS: Mr. President, I wish to say a few words. I think the paper has presented the subject to you in a very enlightening way. I was in a base hospital in this country at Fort Riley for nearly a year and a half. It was one of the largest base hospitals in the country, and perhaps we had some things there which were not carried on in the field. We had a regular post-graduate course there. The men in the different special lines of work were supposed to hold the classes at least twice a week, and it was compulsory with every officer at the base hospital to take at least two hours a week in this course. He could select the course that he wished to take—courses in the different branches, as surgery and the different branches of medicine, pathological work, X-ray work, in fact any other line; and I know that personally I gained a great deal from it, and that the other men did. It was a very exceptional opportunity for the men to bring themselves up in the various lines of work.

I noticed that the Doctor said that every hospital was forced to take care of nearly twice as many as it was rated for. I think we did fully that at Riley, and at the height of the epidemic we had nearly 6,000 patients in the hospital proper; and at the cantonment at Funston, which was four miles from the base hospital, there were about 4,000 men who were not sick enough to take to the hospital. If they had been, we could not have taken them there, because we had every corridor and every veranda full of cots for the men. We had about 1,350 cases of pneumonia at one time, and you can see the great advantage to these young surgeons who were in charge of the wards of the experience that they had in pneumonia; and it was not only in pneumonia but in nearly every line of medicine that they had a wonderful opportunity.

*THE TEETH OF SCHOOL CHILDREN.

By DR. J. L. JOHNSON, Mars Hill, Maine.

I feel that in the first place I should apologize both for the subject and the subject matter of this brief paper. It is really, however, not a paper in the strict sense of the word, but an urgent plea for prophylaxis. I realize, indeed, and perfectly well, that many of you know a good deal more about it than I do myself, but I do so often have it brought to my attention, and oftentimes so forcibly, that I am now induced to say a few words to the point, as well as I can. Last year at this society meeting we listened with pleasure to a very well written and interesting paper by one of our dental friends, Dr. Clifford, upon the subject of the teeth as a source of focal infections of many sorts. Perhaps this paper of mine will therefore supplement a little that very complete consideration of the subject of the teeth from many medical points of view.

Now as to the teeth of school children, the concensus of opinion all over the country, and I am sure that your experience, as well as does my own, will bear out this statement, that the two physical defects which stand out most prominently in our school children are bad and irregular teeth and hypertrophied tonsils with adenoids. So far as my experience goes, at least sixty-five per cent. of all our school children have defective teeth. This means, in other words, that sixty-five children out of every one hundred average school children go about daily with defective teeth. In addition to this personal knowledge, the reports of army medical examiners indicate in unmeasured terms that preventable defects of the teeth were an enormous cause of the loss of army service to the nation on the part of numberless young recruits. This might have been easily avoided and prevented by proper attention to the teeth in the early years of school life.

In so far as the general practitioner and the teeth are concerned, it should first be said, as a matter of course, that the decay of the teeth, in so far as it bears upon the ultimate condition of the grinding mechanism, belongs properly to the dentist. On the other hand, the condition of the mouth and the effect upon the rest of the body from the teeth is distinctly in our field of medicine, and we should, as many of us already are doing, take upon ourselves the responsibility of proper care for them. When we see children of from twelve to fourteen years of age with the permanent molars destroyed, or nearly so,

*Paper read before the annual meeting of the Aroostook County Medical Society, June 26, 1919.

and with beginning pyorrhœa in some cases, or even only slightly decayed teeth with evident lack of ordinary daily care, such a case is likely to come under our care for many causes, sooner or later, and the sooner they come the better. A large majority of the parents of children in the country, owing to financial considerations, or possibly from the merest careless ignorance, fail to obtain any systematic care of their children's teeth. In many such instances, however, the family physician, from coming into frequent contact with many such children, will be all too well aware of their condition. This is a duty of his, also. He is able to understand it, and oftentimes he is the only person whatsoever who can give to children thus affected with poor, decayed and irregular teeth a fair start in life, with reasonably good teeth by some sort of care, and a good deal of stimulating advice.

Some of you may be thinking by this time, what a stale and silly topic to bring before you at a meeting, but it is so closely connected with the relation of the teeth to the rest of the body that it is worth thinking over and saying something about at meetings such as these of ours, and bringing before you now and then, even if mere repetition of thoughts and cases in medical practice.

Coming next to some practical instances of the connection between the teeth and the body, I beg leave to say that during the past year or so I have seen cases of chronic sepsis, due to nothing else than local foci in the teeth and mouth, diagnosticated as ordinary tuberculosis, although no bodily lesion called tuberculous could anywhere be found. I have seen others diagnosticated as anæmia, although no blood examinations had ever been made. "Scrofula" has been brought to my notice, whatever such a disease may be, but without so-called scrofulous symptoms. We hear of kidney trouble, because there is a pain in the back, in the case of men who were tested by careful urinalysis twice a year by life insurance companies without finding either sugar, albumin or indicanuria. Many, too, are the cases of rheumatism treated simply with routine practice of the salicylates, without any thought being given to the actual cause, a focus in the mouth within the roots of the teeth.

Now in almost every single one of these cases, whilst there were, to be sure, some symptoms, classically, of the disease diagnosticated, yet in every one of them there was a stinking, foul and filthy mouth with advanced disease of the teeth and gums. In every one of them there was a decided improvement after the mouth had been cleaned up, although some of them were not totally cured. These instances then coming under my observation were not errors in diagnosis; they were errors in discovering the cause; and in one way or the other

they emphasized neglect upon the part of the attending physicians, among whom I count myself. The mouths of all these patients had never been looked into at all. This is, of course, perfectly stale as news, but from the patient's point of view of getting well, does it seem so awfully silly or stale as a topic for discussion?

It seems a far cry, as the saying goes, from teeth to eclampsia, but in this connection Talbot's paper in the *Journal of Surgery, Gynecology and Obstetrics* for February, 1919, and entitled "A Theory of the Ætiology of the Toxæmia of Pregnancy, with or without Convulsions," is especially interesting. His conclusion, too, that the cause of the toxæmia is not to be found in the products of conception, but may apparently be the result of dental disease, is startling, to say the least.

After this brief series of suggestive remarks let me finish by reporting some cases of connection between the teeth and various constitutional affections.

CASE REPORTS.

Case 1. Mr. P. S. was especially interesting from many points of view. I saw him first in consultation with Dr. Kincaid, of Mars Hill, and found him emaciated to the last degree, as tremulous as a man with the palsy, complaining of enormous loss of weight and strength, and his urine with Fehling's solution produced a very heavy precipitate of a dark orange yellow color. We diagnosticated the case as one of diabetes, although the color of the precipitation was not entirely typical, and we put him on a strict diet. He reported to me a week later, and I made a urinalysis to note what effect the dietary restriction had had upon it, and I found it entirely clear. He then informed me, much to my astonishment, that he had not dieted at all. I sent him home with directions to eat anything he wanted and to return in another two days. He did so and again he was sugar free. Then on a full diet I sent a specimen to Dr. Whittier, at Brunswick, who reported no sugar, no dactetic, no acetone. Then I began to look around a bit more closely, and I soon found that he had a mouthful of bad teeth with noticeable pyorrhœa. I took him by the arm to the dentist and had every tooth pulled, and sent him home with orders to do no work for six months. Instead of that he ran a farm all summer, almost single handed. In the autumn he was not a bit better than months before. During the winter he supplied himself with a good set of false teeth, rested in every possible way through the winter, and in May last, when I saw him again, he had gained at least twenty pounds in weight and was feeling perfectly well and able to do his farm work as of old.

Case 2 was that of a boy about fifteen who was suddenly seized with severe precordial pain, and when I reached him he was breathing with very shallow, grunting respirations, and a cold sweat was standing out in drops on his face. It was necessary to give him morphine to get him any ease and comfort. He had had several attacks of tonsillitis and the tonsils were somewhat hypertrophied, but the teeth were apparently sound, none of them aching or feeling tender in the least. I treated him for a long time with local applications to the throat, salicylates, vaccines, colchicum, and as many other things as I could think of or read about, but all in vain. He frequently had to have morphia for the severe pain. His pulse ran steadily between 110 and 130, and was at all hours of the day or night very irregular. His temperature ranged from normal to 101, he sometimes being for days at a time without fever at all. In spite of all that I could do, he failed to show any improvement. Finally another physician was called, and he soon found an abscessed tooth, had it extracted, and the boy began promptly to get well, and in a short time was doing his share of hard work on a big farm.

Case 3 is that of a girl of sixteen, who had for several months shown steady loss in weight, and had been diagnosticated and labelled as "probably incipient tuberculosis." When I happened to be called in the patient was beginning to have very definite choreiform convulsions, and had previously been treated with iron and arsenic without results. Her mouth I found filled with bad teeth, and after a long and expensive course of dentistry she began to improve, the twitchings gradually ceased, and at the end of six months she was in perfect health and remained so without any other treatment than that which had been directed to her teeth.

Case 4 was that of a man of about fifty years of age who had suffered for many months, off and on, with indefinite rheumatic pains up and down the back. He was one day taken suddenly about 8 in the morning with a very severe pain in the chest running up to the right shoulder and both sides of the neck. He lay doubled up like a case of violent colic when I first saw him. The pain was described as intense, and dyspnœa was very pronounced. The pulse, however, and temperature were both normal. After administration of Dover's powders and the application of hot fomentations to the parts affected he became easier in his feelings. His mouth was found to contain eight bad teeth, with pronounced pyorrhœa. A dentist accompanied me to the patient that same day and cleaned the teeth affected all out. With no other treatment than a dose of salts to move the bowels, the

man recovered immediately, and within a day or two was out to work as usual.

Such cases are by no means rare in ordinary practice and I have simply recalled here the first four that happened to be typical of the relation between the teeth and the general body. I do not advocate in this brief paper the care of the teeth as a panacea for all worldly ills, but they are certainly the plain cause of a great many symptoms and troubles discoverable in patients and which we are called upon to treat. It is for that reason, and likewise for our own advantage in getting good and rapid results, that it is a very plain duty on the part of physicians to talk teeth, and write teeth, and advise teeth, and do everything possible in our power to see that, with good sound, serviceable teeth, the next generation coming along gets a better start toward perfect health, in this respect, than the present one so far has had a chance to get.

The reading of this paper was followed by a vivacious and interesting discussion, almost every member present saying something on one side or the other of the question. In addition to several instances of patients affected with rheumatism and other painful symptoms of that nature, mention was made by the specialists present of undoubted connection between defective and diseased or irregular, yet healthy teeth, and inflammations of various structures of the ear and eye.

Altogether, the paper by Dr. Johnson, though short, proved to be the very kind of an essay that physicians often like to hear, for it gave them a text to say something concerning the connection of the teeth and other parts of the body as they were daily seeing them in active practice. The general idea was that the teeth should be well cared for always, and that the proof of the teeth as a cause of disease in manifold form should depend in the final court of science on the fact that proper work on the teeth, resulting in bringing them into good shape or cleansing or extracting them, should be followed by total disappearance of the bodily symptoms without other means of treatment being utilized.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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*Editorial Comment.***YOUR PART OF MAINE'S MEDICAL HISTORY.**

We believe that now is the time for every County Medical Society to make its effort to cause to be put on paper for preservation, an autobiographical record of what each physician from his county did for the war to preserve the nation from absolutism. We are positively sure that each County Secretary should take it upon himself, at the next meeting after this notice strikes his eyes, to collect what data of this sort he can by a personal talk, or by a notice sent out upon the post card calling the meeting of the society. We want to know just what each physician in every county has done for the war, either at home in inducing fellow physicians to go to the war, or in examining men in his place of practice, or in examining recruits at forts in Maine or elsewhere, or in examining and treating men in base hospitals throughout the nation, and finally in obtaining from men who went overseas the exact place in Europe in which their base hospital was situated, what they chiefly saw, how many cases they had under personal control, what special medical or surgical work they did, and finally their impressions of army medical service.

Such material as this, the items of which might easily be widely extended, can be best utilized in the future by examining in each county, and then depositing in the State, or in the Maine Historical Library. Much, of course, is asked for, from Washington, but the eye of the censor may have been perceived by some, in handing in their

records; but for the State itself we want more freedom of detail and greater open-heartedness.

Such an idea as this may seem absurd to many men not in the war, and to some who actually went, but remain thoughtless of the future for their own fame and the honor of their families. Men of sense are always hunting out the stories of men of renown, and in no way can any man that ever lived do better for his own name than to leave some printed trace behind him, for, without it, he will disappear from the surface of the earth and the memory of his best friends within a very short time after he is dead and buried. Let every county get in its work now, whilst the remembrance of what each man did is fresh within him, and not overlaid with petty items of sordid medical practice day after day for the rest of his life.

MASSACHUSETTS MEDICAL EXAMINERS.

Some of the things done in our neighboring State are well worth studying, approving and copying, for the benefit of the State of Maine. Amongst those good things, there is none more commendable than the encouragement of good work done by the medical examiners, by giving them after one term of office another, and after a second, a third; and so on. Happening to read *The Herald*, of Boston, lately, we were gratified to find a long list of examiners appointed for another term. One of them has had more than thirty-five years of service. These new appointments are reward for merit. They are not political moves. They are not jobs for somebody else who has not a good knowledge of pathological anatomy, nor ever given promise of knowing more.

It is a serious mistake in any law for medical examiners that appointments for this high office should be made for anything but merit, zeal and intention to do good work. No man should be appointed at all, until after the Governor has consulted with the President of the State Association or of a County Medical Society. Together they should go over the men available, and put in one known to be capable. There are too many examiners in some counties. With telephone and motor car, one man can attend to any county. That one should be paid a reasonable salary and continued in office so long as he does good work. Once and for all, the physicians of Maine ought to know that the position of an examiner is to discover crime; to establish it by the highest degree of pathological knowledge; and to prevent the escape of criminals by the wiles of baffling attorneys showing up the inefficiency of the examiners, if in any underhand way it can be done.

We are sorry to note that one of our good examiners has failed on a new term of office; it is not a good example or encouragement to his successor to do good work.

The JOURNAL intends to put up a fight at the next Legislature for the improvement of our law for medical examiners, and to set up as a standard that the appointment shall be a proof of satisfactory knowledge of pathological anatomy and of studies in medical jurisprudence.

GOVERNMENT WANTS WORKERS IN VENEREAL DISEASE CAMPAIGN.

The recently created Interdepartmental Social Hygiene Board of the United States Government is in need of a number of specially trained men and women to complete its organization. The United States Civil Service Commission has announced examinations for the following positions: Chief of division for scientific research, \$3,500 to \$4,500 a year; chief of division for educational research and development, \$3,500 to \$4,500 a year; educational assistant, \$2,800 to \$3,600 a year; chief of division of relations with States, \$3,500 to \$4,500 a year; chief of division of records, information and planning, \$3,500 to \$4,500 a year; supervising assistant and inspector, \$2,800 to \$3,600 a year; field agent, \$1,800 to \$3,000 a year. All positions are open to both men and women.

Applicants for these positions will not be given scholastic tests in an examination room, but will be rated upon their education, experience, and writings. Published writings of which the applicant is the author will be submitted with the application. For most of the positions a thesis on one of a number of given subjects will be accepted in lieu of published writings. The receipt of applications will close on November 4. Detailed information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or from the secretary of the United States Civil Service Board at the post office or customhouse in any of 3,000 cities.

The law creating the Interdepartmental Social Hygiene Board provides for the co-operation of the War and Navy Departments and the Public Health Service of the Treasury Department for the prevention, control, and treatment of venereal diseases. The duties of the Board as set forth in the act are (1) to recommend rules and regulations for the expenditure of moneys allotted to States for the use of their respective boards or departments of health in the prevention, control and treatment of venereal diseases; (2) to select universities, col-

leges, or other suitable institutions which shall receive allotments for scientific research for the purpose of discovering more effective medical measures for the prevention and treatment of venereal diseases; (3) to recommend such general measures as will promote correlation and efficiency in carrying out the purposes of the act; and (4) to direct the expenditure of certain moneys appropriated by the act.

LACK OF MEDICAL LITERATURE IN MAINE.

Happening to read a paper in the Colorado State Journal of Medicine, we were struck with the large number of papers on medicine and surgery contributed to the medical literature of the nation, in the Journal of the A. M. A., and others throughout the country. A long list of papers was printed, with names of writers and topics considered, and together they made a fine contribution to medical and surgical advance. Turning then again to the indices of various medical papers metropolitan, or of the A. M. A., we looked and mostly in vain for papers contributed from the physicians of Maine.

Why should this be so? Why should Maine physicians be unable to write papers of value to the profession at large? The answer is plain, and to the effect that the members of the profession get no training, anywhere, during their medical educational years in the schools, or later on in various medical societies. All medical schools should make it a part of medical education to inform scholars how to write papers. The beginnings are easy, namely, first to watch the cases that they may see, then to make notes concerning them, and finally to put them into readable shape. Some man competent to teach students just how to do this work should be found on the staff of every medical school. With the start then obtained, it would be easier for men who become internes in Hospitals after obtaining their degrees, to work out the case histories of the very large choice of cases which they see medically and surgically in the hospitals so numerous scattered about. Having once got the ideal for a paper, they could improve in style and wording, and in the course of their four or five years of education be able to write papers worth reading, worth listening to, and better still, worth printing. For, we are not practicing medicine simply for money, we are practicing it because we see that we do good to a certain class of people who need our services, and it is a plain duty for us to encourage other practicing with the same ideals, to continue their good work by reading our experiences, and printing them, for the common benefit of the profession. Let us make a beginning for more and better medical papers in Maine by teaching young men the art of writing a readable, printable, instructive medical paper.

AIMLESS COUNTY SOCIETIES.

We note in a late number of the Texas Medical Journal an inviting editorial on this curious topic, for in some of its suggestive remarks we are reminded a bit of some of our own County Societies. The original enthusiastic ideal of joining in with other physicians has been carried out, but gradually comes the loss of aim. Nowadays, the war has been to blame for this by seducing active members into service, so that their enlivening presence is lost. No means seem, either, to have been taken to urge absent members to keep in touch with those remaining at home, so far as the military censorship would permit, by the writing of letters, or handing in of medical studies from hospitals or overseas. How much has thus been lost to medical advance will never be known, but for it, some one has been sadly and ignorantly to blame. And what a pity it is and will ever continue to be!

Then again, new advances keep coming to the front, but they remain unclassified and confused and for that reason County meetings have lost an aim. We live between the war and an unfinished peace, turning around in a whirlpool of conflicting currents of practical medical thoughts and laboratory statistics. No one seems to know just how to write, so that we remain as in a tornado, whirling around and around, and making only a circular progress in a rut of ancient themes.

New leaders are called for, and new topics for discussion. Every physician in Maine knows that the nation would be better off for a compulsory examination of all the school children, but if this is brought forward it is not physicians who act, but the school authorities. Instead of volunteering to tell the people just what these examinations are, and what good they will do the few who may be interested want to know how much there is in the job. Our law for Medical Examiners is deplorable, in its inefficiency, yet instead of having such an aim for discussions at meetings, everybody is mum. How can the present law be improved, except by discussing its defects, plainly, no matter whom it hits.

Do we not all know that pathological knowledge diluted amongst four medical examiners in a County tends to destroy the protection due to human life? Such knowledge should be concentrated into one examiner. Do we not all know that our examiners are treated with scant courtesy before the Courts, because the knowledge of each individual is small compared with what it might be, if there were one only in each County sure to learn something in time, at all events. Yet the moment that one of them has worked out his term, out he goes to make room for whom? For any one who knows as much, or more, or even less than the one discharged? Politics should be abolished

from the medical examiner question; merit should be the standard; the County Presidents and the State President should be consulted for every appointment, and men once in should be paid well, one for each County and no more until population increases largely in any county in Maine. How absurd as at present, that all four are chased down for a given case, only to find on their arrival, that one has the post mortem, whilst the rest motor home dejectedly without even being paid for their wasted time.

Endless are our meditations on aimless County Societies. Here, however, are some thoughts on two live topics for discussion throughout the State and as it were a visible aim for physicians to shoot at for a prize essay for the benefit of the Legislature for 1921. Surely, new topics for papers are needed, and higher ideals than the mere monetary rewards of daily drudgery in the practice of medicine, unless our County Societies and with them ultimately, the State Association, drift aimlessly along.

ACNE AND SOME OF ITS CAUSES.

Strickler in the A. M. J. of the Medical Sciences has lately recited his views on the cause of this troublesome affection, which, even if not dangerous, is uncomfortable and distressing mentally to those afflicted. He first emphasizes gastric symptoms as suggested by other observers which show hyperacidity of the stomach in half of the cases, retention ptosis and atony. Almost every patient reveals gastric abnormality or intestinal. Gastro intestinal combined symptoms occurred in nearly 90 per cent. of all cases. After suggesting proper investigation of those conditions, he remarks that acne is due in a vast majority of cases to the acne bacillus, activated by the causes already mentioned, although the chief are the colon bacillus or its toxins or both. Other cases are due to internal use of certain remedies, or to local applications. In some cases the thyroid is enlarged; cosmetics may be at fault; puberty, anæmia, and pelvic diseases have some importance in causation, but they rarely if ever are actual excitants of this troublesome and obstinate affection of the skin. Take care of the digestion of proper food in proper amount and utilize autogenous vaccines might be added in the way of treatment.

During August the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion with New and Non-official Remedies:

Calco Chemical Co.: Cinchophen-Calco.

Geck Laboratory: Culture-Lac.

Eli Lilly and Co.: Tetanus Antitoxin-Lilly.

Fred I. Lackenbach: B. Coli Bacterin (Spec. Bact. Vac. No. 12). Gonococcus Bacterin (Spec. Bact. Vac. No. 9). Staph-Acne Bacterin (Spec. Bact. Vac. No. 6). Whooping Cough Bacterin (Spec. Bact. Vac. No. 14). Staphylococcus Bacterin (Spec. Bact. Vac. No. 1). Streptococcus Bacterin (Spec. Bact. Vac. No. 10). Typhoid Bacterin (Spec. Bact. Vac. No. 11). Typhoid-Paratyphoid Bacterin (Spec. Bact. Vac. No. 13).

Notices.

VENEREAL DISEASE CONTROL.

When the division of venereal diseases in the U. S. P. H. service was established, the plan of procedure was grouped medically, legally, and educationally. The educational measures consisted in sending out leaflets, moving pictures, exhibits, lectures and stereopticon views in every walk in life,—homes, churches, schools, and workshops of all sorts.

The legal measures included the closing of restricted districts, enforcement of laws against prostitution, establishment of institutions for building up the venereally infected, and the commitment of the venereally infected feeble-minded. Moreover, legal measures to report venereal cases, to prohibit quack advertising and the sale of venereal nostrums, were instituted and widely carried out.

Medically, clinics were established, laboratories were put into active use, the support of the profession called for, the co-operation of druggists urged, and the assistance of dentists, nurses, and all medical, pharmaceutical and dental schools, societies and journals enlisted.

Medically, the campaign was begun with advertising; newspapers and magazines were appealed to, to stop advertising obnoxious notices, with the result that out of some 20,000 newspapers and magazines in the nation, more than 99 per cent. are helping out the great cause. Druggists were then followed up with a view to induce them to stop selling nostrums and urging applicants to consult the profession, and in this direction of work more than half of the druggists in the country have co-operated with good results already.

As to physicians, some one hundred and thirty thousand were appealed to and agreement cards of assistance have been received from nearly one-half of the whole so far. The campaign with dentists, nurses, schools, societies and associations is being begun, and for the extension of all this work in its manifold ramifications, the aid of physicians throughout the country is once more urgently asked for by the Surgeon General of the Public Health Service.

The JOURNAL takes pleasure in encouraging a work of this sort, which is sure to be of benefit to the nation in incalculable ways for the future. For instructing every single patient concerning the dangers of

the venereal not only to the young and healthy, but to people of all ages and in every class of life, they are doing good work for the future of the nation; they are promulgating good health; they are doing their share to prevent the occurrence of the most enfeebling and the farthest reaching of all the diseases with which the human race is afflicted; and oftentimes owing to no fault of thousands of innocent women and their offspring forever.

FOREIGN BODIES IN THE STOMACH.

Instances of foreign bodies in the stomach have been reported from time to time, but the most extraordinary on record is that mentioned by Winslow, in the *Annals of Surgery* for July. For the foreign bodies removed from a patient's stomach numbered no less than 1,290, including over 1,000 straight pins, 100 hairpins, 45 safety pins, with additional pieces of wire, bent and straight buckles, clasps and paper clamps. Two skiagrams add to the value and curiosity of the case, which additionally is enriched with a bibliography of some other very memorable and similar instances. Almost all of the patients exhibiting such foreign bodies are insane, but occasionally they are traveling magicians and mountebanks.

INDEMNITY DEFENSE FUND.

California enjoys the distinction of a fund of this sort raised voluntarily by an assessment of thirty dollars for each member with the avowed purpose of paying damages in malpractice suits against its members. Started in 1916, has been attacked in the courts several times already by malpractice suits, but winnings are larger than losses, so that in three years the fund has lost only one thousand dollars. Its present membership is nearly five hundred. This is, we believe, the only fund so far established for actual payment of indemnities, whilst in other states the funds on hand pay for defending lawsuits and make heroic endeavors to prevent such suits and to compromise them, when the chances are very much against the physician involved.

We print this note simply to offer to our readers some idea of various means tending to a systematic and organized plan for medical defense throughout the nation.

Finally, it is to be noted, that in California, as planned at present, the average loss per capita is one dollar a year, about a twelfth of what it costs us in Maine to insure against lawsuits.

North Dakota having begun to agitate against such insurance, the profession needs to awake to its dangers from ultimate loss of insurance and to the necessity for medical defense.

Prescribe "Horlick's" for your patients convalescing from Influenza and concurrent epidemics.

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Medical Notes.

SOME BRITISH MEDICAL NOTES.

Novocain Injections; Acraflavine in Gonorrhea; Bipp; Gas Poisoning Symptoms; Shot in an Appendix; Motors for Medical Men Scarce; Professional Confidence; Incontinence of Urine; Encephalitis Lethargica; Late Hydrophobia.

Novocain injected extra durally is proving of great value for operations on hemorrhoids, fistulas, perineal abscesses, urethral strictures, and so on. It also serves well for curetting, but not so well for dilating or stretching. It is worth while studying in cystoscopy and in bladder operations. The only difficulty is in locating the sacral hiatus, through the approximate centre of which the injections should be made. The precise method of doing this, and notes concerning errors likely to occur in carrying it out, can be studied and mastered from a paper by Meaker in the *British Medical* for May 10, 1919.

The acriflavine gonorrheal treatment is much the fashion now in England, the solution being made 1 to 4,000 and care being taken to drive it well down—into the deeper portions of the urethra, where the greatest infection lies. A pint at a time, twice a day, is generally used in hospital treatment.

Bipp (bismuth iodoform and paraffin) is the latest aseptic in the mode in London for fresh gunshot wounds and wounds of every sort. The proportions are bismuth one part, iodoform one part, and paraffin three.

Although gassing has practically ceased for the present, it may be seen again in sporadic outbreaks of war on continental Europe, and it is well worth while to remember that it produces mostly respiratory affections, whilst those of the heart and kidneys are rarer. The annotator adds, that he has lately seen an instance of extreme loss of hearing from an attempt at suicide by illuminating gas, and is rather surprised not to observe amongst the symptoms of gassing any permanent effects on the sight or hearing.

We read with some little curiosity of a case of appendicitis, in which the skiagrams revealed two small shots "rattling around" in the apex of the appendix. The operation removed them successfully. It was thought that the patient had swallowed the shot while eating game.

British medical men are having hard times in getting motor cars in which to run their practice. Government having commandeered many of their cars at the beginning of the war, are offering them back to their medical owners for from three to five times the sum which was originally paid upon commandeering by the government. This is a curious state of affairs, and makes country and city practice alike very difficult.

Tincture of Arnica Montana in a one per cent. solution in water, in five drop doses every other day for two or three weeks, is promised as a useful remedy for the incontinence of urine following confinement.

The British Medical Journals are overflowing with correspondence concerning a case in which a physician in attendance upon a woman suspected that a child had been born in the room, although there were no traces of an infant, living or dead. The woman was haled before the courts for criminal concealment and alleged infanticide, but as there was nothing to show for it, the judge tried to extort a confession from the attending physician. The gentleman refused to testify in any way except as to facts observed and claimed professional confidence. The judge claimed that the physician ought to tell just as much as if he saw a man cut another man's throat. But the physician was not to be moved. The Journals consequently, in taking up the

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occurrence, praise the physician for his standpoint of professional confidence. The Union for Medical Defense has also taken up the case and urged physicians invariably to cling to their professional oath.

Cases resembling encephalitis lethargica have been raked up for publication as occurring during the influenza epidemic of 1918. It is generally believed that this curious disease is one of the manifestations of the influenza germ, in certain persons of a lymphatic constitution, so called.

Sir Peter Fryer reports afresh a curious case of fatal hydrophobia, examined at the time by several physicians, all of whom concurred in the diagnosis. The reason for bringing it up again was because the patient had been bitten eighteen months before, but showed no hydrophobic symptoms until after that long delay. Sir Peter is of the opinion that the poison of a mad dog may remain localized in the wound for a long period of time, and for that reason, that seeing the patient early, the wound should be cauterized with hot irons, burning coals, or other means, whilst additionally, if a person was ever seen with the cicatrix of a bite from a dog supposed to have been mad, no matter how long before, it is the surgeon's duty to go in under the scar, clean it out, and cauterize it thoroughly.

NEW AND NON-OFFICIAL REMEDIES.

Barbital Sodium-Abbott.—A brand of barbital sodium which complies with the New and Non-official Remedies standards. Barbital sodium is the soluble sodium salt of barbital (veronal). Barbital sodium was first introduced as veronal sodium and medinal. For a discussion of the actions, uses and dosage of barbital sodium see New and Non-official Remedies, 1919, p. 83. The Abbott Laboratories, Chicago.

IVY POISONING — A FIVE FINGER PREVENTION.

Prevention is better than a possible cure. Ivy dermatitis is dangerous, and sometimes causes death. Prevent it, by teaching children (yourself included, as a child in ivy knowledge) that any vine with groups of five leaves like your own five fingers can be handled safely in your hand of five fingers. Any vine or shrub having leaves in groups of less than five, as is the case with poison ivy, for instance, is risky to handle. Here, then, is an axiom: Five fingers, five leaves in a group, is safe to handle, otherwise dangerous. This is the time of the year when ivy poisoning is not uncommon, and this is the time to learn this simple axiom.

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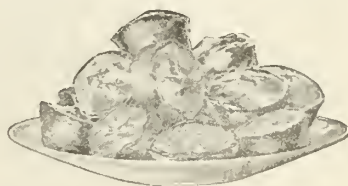
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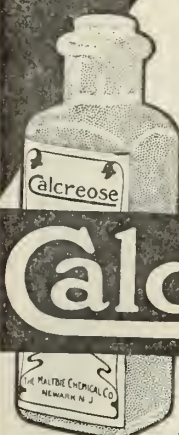
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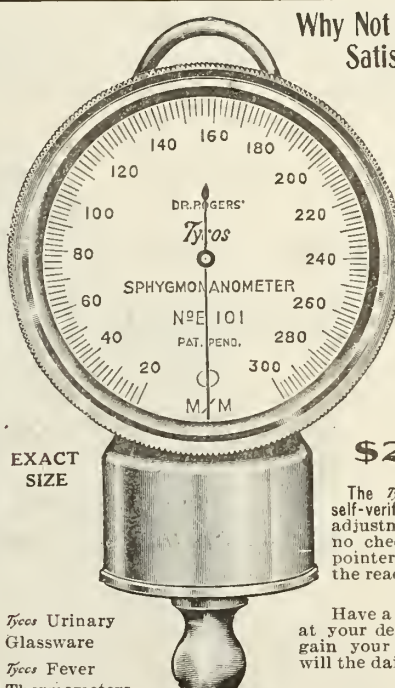
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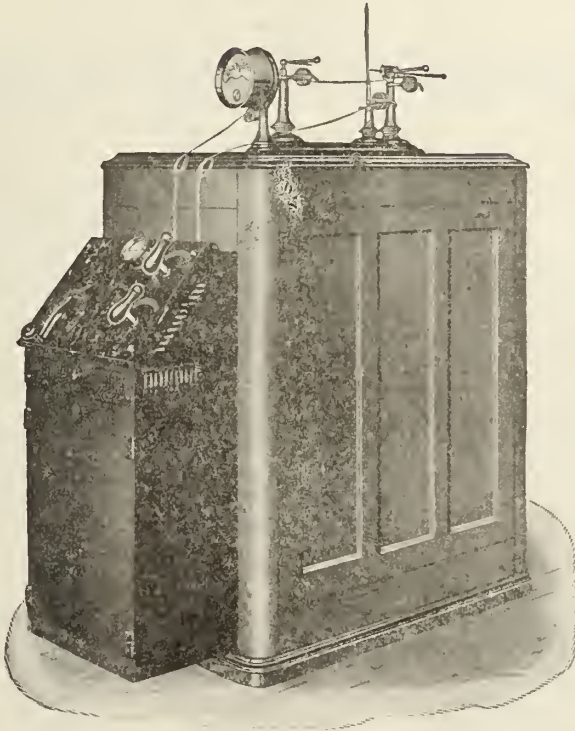
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VOL. X.

OCTOBER, 1919.

No. 3

*THE MEDICAL WORLD AFTER THE WORLD CATAclysm.

By CHAS. E. BANKS, Assistant Surgeon-General.

This opportunity and privilege to address this scientific body, the first to which I was affiliated after my graduation, is due to no personal merit, nor as a selection to make an important official pronouncement, but to the indulgent friendship of men of my native State and friends of my boyhood days who have remembered our earlier associations with continued and affectionate interest. I am honored by their recognition as worthy to follow in the footsteps on this platform of distinguished professors and scientists who have addressed you in the past. Had I consulted my personal inclinations—as public speaking is not individually attractive to me—I should have found some euphemism to act as a vehicle for a polite declination, but I could not honorably refuse an invitation so cordially extended, nor conscientiously fail to meet the obligations of personal and professional ties, which always bound me to my friends and brothers in my old home in my native State. To return to it under any circumstances is a delight and an inspiration, but to be invited to come hither as a guest of this distinguished association is indeed a delight tripled.

One's thoughts and sentiments thrive best under the stimulating influence of well remembered scenes and are generated by the renewal

* Annual oration at the sixty-sixth annual meeting of the Maine Medical Association Portland, Me., June 17, 18, 19, 1919.

of friendships that have always been lasting and true. The vigor of one's mind is refreshed by drinking deep draughts of the springs that fed his childish fancies. These ancient streets are in vision once more peopled with the spirits of my kindred who have gone before, and I can conjure in my imagination the scenes of my younger days when life was scarcely more than a day's journey ahead and the choice of a vocation found expression in the usual fantastic dreams of the boy.

"The boy's will is the wind's will,

And the thoughts of youth are long, long thoughts."

Here I drew from the founts of knowledge the common school education which is the privilege and inheritance of every New England child. Here I began the study of medicine and served through the period and observed the curriculum required of the medical profession a generation ago. To it I came back proudly clasping the coveted parchment for which I had labored for three years. And here I first launched my ship upon the troubled waters of private practice. From hence I steered my craft into the larger expanse of the national service. Recollections of a few delightful years on two different details are now intermingled with the chastening thoughts of faces I shall miss who were once companions of my professional life. To those who, like myself, have weathered the storms and outridden the seas of the past I tender my respectful salutation and affectionate greetings. All else is a poor substitute for the endearing friendships of youth. I come back to this land of enchantment and to this delightful environment to be a boy again, and to pay filial homage to the land that bore me.

I was appalled to observe my share in your program set down as an oration. I trust when I have finished you may have gotten some imitation glimpses of a Demosthenes or a Webster, but I doubt it, as the graces of oratory and the felicities of expression are neither a part of my inherited instincts or latter acquirements. I believe the program should be amended to indicate that it is less of an oration and more of an informal talk.

I have not thought to engage your attention by a dissertation, however profound, upon some abstruse technical subject, for medical conventions, according to my view, are scarcely the opportunity for learned essays that smell of the lamp; nor can I think that antiquarian lore, describing the conditions of medical practice in provincial times, would be worthy of your enforced detention while the annual orator is filling his lungs and puffing his cheeks. It has occurred to me that I could arrest your attention by enacting the role of a gentle guide, a constructive philosopher and a critical friend; to turn your thoughts from the past or the present, and to focus them upon the future. Thus I

shall escape ultra scientific judgment, might forestall the musical and stertorous breathing of those who have no thoughts for the past and from my vantage point as a prophet make predictions that may not be successfully contradicted. From this latter standpoint I have chosen to speak of a situation of our profession that may develop after the present world war. Peace is not yet come, but it is on the way. The lark rises from the battle-trodden fields of Flanders and its song is heard as it mounts to the skies. The bruised lilies of France again raise their bended stems in token of resurrection from the crush of the heels of the invaders. The hum of industry is beginning to resound faintly in the shattered cities of Europe, and we can assume that a great war is actually, if not technically over. In this war the medical profession performed a part heretofore undreamed of in the annals of the military world. It did its share nobly and its record is beyond the faint praise of an oratorical neophyte.

The great national army survived the usual ordeals of camp life, always more deadly than the carnage of battle, because of the authority vested in the medical corps to give practical demonstrations of advancing knowledge in medicine, surgery and sanitation. This corps, which held the flower of the younger medical men of the country, numbering thousands, is now partly demobilized, and all will soon be at home again to take up the tasks of the medical world in America after the world war in Europe. Are these tasks to be different from those in the past or are we to return to the same pastures and browse on the same herbs in the same prescribed way? We cannot escape if we would the developments of social conditions which all classes of people must meet in the reconstruction period. Rather, indeed, should we all strive to be leaders and advisers of the people, as we have a right to be, in anything which relates to a diseased body politic, as we are advisers to the individual sufferer. It would be futile for us to argue that the body politic has not been out of order and needs examination and treatment.

One of the changes which will be wrought in our medical world will be of an involuntary character thrust upon the profession by the exigencies of the great military cataclysm itself. This change will be demanded by the four million soldiers taken from primitive sanitary conditions existing in their homes and brought into the newer atmosphere of hygiene and sanitation in the military camps. These young men, who will constitute the potential factors in public life in this and the next generation, have been led into a deeper knowledge of the meaning of preventive, sanitary measures and the value of personal and community hygiene. The young man from the East Side, whose tene-

ment bath tub found no better use than as a receptacle for coal and kindling; the farm laborer from the West, whose highest idea of sanitary surroundings was to erect a cumulative privy within smelling distance of his kitchen and dining room, have been taught the lessons of cleanliness in the barracks and the requirements of decent living in the construction of their company latrines. The doughboy has learned that personal hygiene multiplied is in its ultimate result community hygiene. This untutored private has seen remarkable results of camp sanitation in cantonments numbering a population of from forty to sixty thousand men each, the reduction to a negligible minimum of the preventable communicable diseases dependent upon filth or insects, the comfort and cosmetic values of cleanliness in the barracks, and will return to his home imbued with practical beliefs and experiences of his two years of modern sanitary living. He will go back in many cases to a community where the old-time methods of town and city health regulations consisted principally in white-washing garbage barrels to give an impression of cleanliness and where the feeble campaign against typhoid fever was centered in the faint squeak of a health officer repeating parrot-like: "Swat the fly, swat the fly." Can it be supposed that this formerly untutored man in the barracks, now a graduate in the school of practical hygiene, will tolerate the slipshod methods of so-called health work in the past? Will he accept as a visible sign of sanitation the spasmodic efforts of the half-time officer whose munificent salary of a few hundred dollars per year must be eked out by his personal interests in a private practice which demands his energies and time? The medical profession will find this one of the striking changes following the world war, and behind our efforts to improve the methods of hygienic living will be found this great army of discharged men who can and will second any effort to raise the standard of personal and community hygiene to the level understood by him as effective in his military life in the camp and the trenches. Of course, much of this will lack the effective control that is a part of military methods, but the wonderful examples of a people following without compulsion the requirements of our war situation during the struggle in various forms of abnegation will find equal opportunity to contribute to the common welfare in the newer requirements of sanitary and hygienic environment necessary for the well-being of a nation.

CO-OPERATIVE MEDICAL PRACTICE.

The whole tendency of modern society is toward co-operation in homogeneous lines of effort. Capital and labor in their myriad forms of relationships are becoming more and more a co-operative unit,

whereby greater quantitative and better qualitative results are achieved. The much discussed forms of combinations in restraint of trade and wicked trusts are the natural evolution of modern experience and thought, however illegal they may be declared by statutory enactment. The war itself was fought by the victors in a pool of their resources and a union of their strength. Each belligerent contributed certain forms of power to push back the on-rush of the hordes of destruction. Conditions in domestic and business life are gradually approaching a condition of social co-operation and in many avenues approaching paternalism. If we have reached certain degrees of development through competitive waste it has come to be considered a loss of valuable effort to maintain single costly destructive units when better results could be obtained by combining strength and saving time. In the medical world this germ of co-operative effort must find concrete expression in the adoption of this sound business method of the commercial world. It is perhaps undignified to speak of the doctor's office as a shop before which is parked his latest model Ford and wherein his wares are spread and his instrument cabinets, his electrical machines and his nickel-plated devices for spraying cavities or illuminating interiors are a part of his show room propaganda; but for the purposes of argument each member of the profession peddled his wares and plied his trade in these surroundings in competition with his fellows. The greatest good to the greatest number being a part of the altruistic aims of the profession, it need not be said that all this individual effort represented wasted energy. Other professions combine with wiser knowledge of the needs of society.

The old-time squire who dealt out law from his one pair back or his two pair front office is a relic of the past. He who would advocate a continuance of this is a fossilized dreamer. With better perception of the needs of the people our brothers of the law unite in co-operative effort. Legal firms with four and six names on a shingle announce to a litigious public that their office offers the special knowledge of a corporation lawyer, a criminal lawyer, a patent attorney, a realty expert and a barrister skilled in the art of securing divorces while you wait. All this under a single canvas. A four-ring circus for one price of admission. These legal combinations are not the union of the mediocre of the fraternity, but the greatest lights at the bar are members of these consolidated firms.

Already some of the wiser of our profession have learned this lesson, and business firms, if I may so characterize them, four or six medical men, have joined forces and offered to the public the variety of specialized training to the diseased and injured of their locality.

It need not be said that this is to the advantage of the patients, who find in a convenient suite of rooms the combined product of examinations supplementing each other in the various systems of the human body. If I may again use the colloquialism of those in trade, co-operative practice will be one of the developments of this war, not only from its logical value but from the experiences of our profession itself in its late military practice, where the medical corps of the army was organized along co-operative lines. The profession itself has been developing for many years into specialized practice, which logically leads to combinations of effort. Indeed, one humorously expressed this situation as presaging all possible combinations of specialties: If a patient had swallowed a false tooth, a dental surgeon should be called to extract it. If perchance it were a canine tooth, let the veterinary be summoned.

A medical business corporation is the logical sequence. Instead of going from office waiting room to office waiting room, as fancy or the front-door signs or misguided friends may advise, and obtaining disjointed diagnosis and variegated opinions, many having their foundations in jealous rivalries, the more fortunate victims of disease or injury can now go to a working team of medical and surgical practitioners who give him the "thrice over" at one seance. The patient has had his nervous, digestive and special organs examined by specialists of the firm, whose combined charges for this advantageous method would not exceed, if it equalled, the separate costs of individual physicians. The patient is thus given the benefit of organized professional labor. This is an improved condition of medical practice which the profession owes itself and the public. To the poor man and the man of moderate means this offers the opportunity of obtaining the maximum results with the minimum cost. To the man of wealth it will make no particular difference, but it has increasingly become a part of the duty of a profession like ours, so intimately connected with the health and well-being of the people, to see to it that the less favored portion of society be given like opportunity and means of obtaining the best medical advice as is now vouchsafed the wealthy. The health of a people is unofficially in our keeping, and the medium of maintaining it is a public duty entrusted to the care of the medical profession.

MENTALLY INCAPACITATED.

In the past the State has expended vast sums of money, wasted untold pounds of energy and lost incalculable periods of time in the development of institutions for the care of the mentally incompetent, the unfortunate deficients whose condition was due to diseased condi-

tions, which if properly managed, would make them again active, useful citizens. This is another form of attempting to lock the stable door after the horse is stolen and has been applied to the unfortunates among the adult population. As feeders to these institutions are the various types of so-called reformatories for youths of both sexes who are deemed incorrigibles. These are to become the potential fuel for feeding the fires of almshouses, asylums and penitentiaries (penal institutions). In this well meant, if misguided effort, the profession has borne its share of responsibility as advisers of the community. The day of indiscriminate commitment of these unfortunates to a dreary round of reformatory, asylum and institutional life is approaching its setting sun. The origin of the troubles of these unfortunates has been overlooked by the profession. Many of these victims of social injustice, the creatures of untoward circumstance, are in reality suffering from physical ills possible of correction by intelligent surgical or medical treatment. It will be the duty of the medical world to revise its attitude towards this phase of our social life and assist in educating the public in the necessity of public clinics and school census examinations whereby the germs of future misfortunes, attributed to mental diseases or moral aberration, can be disclosed in time to prevent ultimate disaster to the individual.

The keynote to a saner conception of this condition lies in reaching the trouble at its beginning in the early years of childhood. The girl with adenoids, the boy in need of circumcision, the child with defective vision, the youth with middle ear disease—all carry with them the possibilities of retarded development, and consequently immature qualities in advancing age. The experiences of the medical corps of the army in its examination of the four million men composing the drafted army has laid the foundations for a fairly accurate census of the neurotics, the psycho-neurotic and the psychosis of our young men between twenty-one and thirty-one, and the figures run into the tens of thousands. The medical profession alone can give authoritative voice to this need of the physical examination of school children at the expense of the state to drain this poison at its source. School examinations have been inaugurated in the past, but these have been largely of an expensive and superficial character performed without standards and conducted by underpaid officers of health or school boards, indiscriminately. The medical world owes itself the duty of pricking itself into better and higher work in this important relation which it bears to society. In this connection it may be of interest to note that the number of mental defectives rejected by the draft boards of the national army numbered 5% of the more than 3,000,000 men examined, or 150,000.

THE PHYSICALLY INCAPACITATED.

The recent selective draft has also furnished the medical profession with an unparalleled source of information regarding the physical condition of a nation's manhood. This knowledge, derived from the records of men examined for military service by the draft boards, comprises a grand total of 3,208,446 men between the ages of 21 and 45 physically examined. Of this number nearly 1,000,000 were found to be physically disqualified, partly or totally, and were rejected, while nearly 100,000 were placed in a remediable group for operative correction or internal medication, while a third of a million were placed upon limited service because of physical disabilities. Of this number the percentages of rejections by local boards and camp surgeons gives the following instructive material for consideration:

Cardiac disease	13.1
Bone and joint defects	12.3
Optical defects	10.6
Tuberculosis	8.7
Developed mental defects	8.4
Hernias	6

It is especially discouraging to find that the degenerative diseases have such a large hold upon our youths. The country will expect an answer.

Of over 3,000,000 men, 2,259,027 were found physically qualified for military service, a total of 70% of the entire number examined, but 8.1% of these were finally rejected by the camp surgeons, leaving only 64.71% of the registrants in the age group fully qualified for all military duty. Topographically considered, 21% were rejected as from cities and but 16% were rejected from the rural districts. The white registrants had 1% better record than the colored and the native born 4% better than the alien. Undoubtedly the physical examinations of so many men taken indiscriminately and proportionately from all sections of the country constitute a fair index of the health of the general population: And we are forced to the conclusion that the health of the country is far below what it ought to be. This is especially true when we consider and weigh the fact that only 65% of our young men, over 3,000,000 in number, were found fit for military duty. In Maine the record is even less than that, being only 62% found fit out of 22,000 examined from this state; 3,886 were totally disqualified and 3,378 fit only for limited service, a total of about 33% disqualified. The figures from all sections of the country are sufficiently appalling to show that it is of the greatest importance to the nation to have the

causes of the physical unfitness searched out and the proper remedies applied. It is the supreme duty of all agencies, national, state and local, to work together to accomplish these purposes, and in this important work the medical profession has a call to leadership which it cannot evade. The country will look to us to learn why one-third of its manhood is physically below the standards of military requirements.

DISEASES CONNECTED WITH THE SOCIAL EVIL.

In the past the medical profession has been the greatest bulwark against publicity in the matter of the so-called social diseases because of its adhesion to the standards of professional ethics and its legally buttressed relations of a confidential character with its clients. It seems to me that a consideration of the character of venereal diseases as a national scourge should arrest the attention of the profession to its duties to the community at large as having equal importance to that of the physician to his patient. A syphilitic at large is a cesspool of corruption. A gonorrhœic roaming at will is a traveling museum of potential horrors. Combined they infect the tap root of our national life. The medical world has protected them as confidential clients. It should now regard them as the source of disease and the seeds of living death. The public is now astride the back of the profession, driving it to co-operation in the prevention of the spread of these diseases. In principle they are on all fours with every other infectious disease. The great pox is not different in essence from the small pox; the one happened to be acquired under the secrecy of illegal relationships and has been accorded the sanctity of silence. Statutory enactment for the reporting of venereal diseases has been rendered nugatory by the refusal of the profession to report the cases to the health authority. We should awake from this attitude of smug complacency in our ethics and consider that the public interests are paramount to that of a private sinner. The present war afforded a welcome and a valuable opportunity for inaugurating a campaign against venereal diseases for the protection of the health of the fighting forces. Extraordinary powers were given the national authorities to enforce restrictive measures, which included arrest and punishment of carriers of venereal infections. The American Congress has laid the foundation of a nation-wide campaign of prevention, publicity and present care of diseased persons. Coupled with this obstructive attitude of the medical profession has been the ostrich-like habit of the Anglo-Saxon to turn his back and bury his face so that he might remain in ignorance of the plague that has been sapping his vitality. The beginnings already

made are tentative and experimental and can only become permanent factors by the hearty co-operation of the medical world in putting teeth into the laws which provide for the inclusion of venereal among the reportable diseases and the quarantining of distributors, professional and otherwise.

The medical profession, in the prosecution of this laudable work, can lend its powerful aid to educational campaign for accomplishing venereal disease control by bringing to the people of America a knowledge of the effects of gonorrhea and syphilis on the health and efficiency of a nation. Special methods of this educational campaign, to be undertaken by the medical fraternity, are the carrying on of co-operative work with the Rotary Clubs; the development of programs to be carried out by large employers of labor; the campaign through the churches of the country and the clergy; the creation of a sentiment for the elimination of advertisements of venereal nostrums and of business cards of quack doctors from newspapers and magazines, and the support of business men in upholding the hands of the constituted health authorities in securing proper curative treatment of persons venereally infected. Public sentiment is ready to be crystallized. The world war has left this heritage of endeavor to us. We must not fail to heed the summons.

INDUSTRIAL MEDICINE AND SURGERY.

The battle casualties of the great war have not seriously added to our army of crippled as was naturally to be anticipated. When we entered into this most deadly of all conflicts our active participation in it covered such a short period that we escaped comparatively fortunate in this respect. Altogether there were less than a quarter of a million of wounded, most of them of a minor character, resulting in temporary disability. There will not be more than 3,500 amputations from all causes in our army of 4,000,000. The blind number 126 only, and therefore our problem of rehabilitation of the crippled is comparatively a small one. I mention these, not for the reason that we may congratulate ourselves on the avoidance of a great reconstructive program, but to invite your consideration of a growing factor of like character in our civil life, which the profession must meet in the coming years of development. Community life to-day in America is an organization of increasingly complex growth. Conditions of life and living have changed in the last century through the introduction of motive power, steam, electricity and the oil burning engine. A hundred years ago all labor was manual; now, with labor saving machinery entering into the mechanical activity of mankind, our country is one vast machine shop,

comprising in its horizon all the material and physical possibilities consequent upon occupational traumatism and diseases.

It has been estimated that there are annually occurring in this country not far from a half million serious and crippling injuries to workers in industrial plants. Of this number about 15,000 result in permanent disablement, notwithstanding the persistent "Safety First" campaigns which have been inaugurated by societies and associations of employers and employees. In addition to the accidents there are the occupational diseases of which tuberculosis takes the largest toll. While figures of a satisfactory kind are not available, yet estimates of the annual loss through preventable illness to the workers in this country is not far from eight or nine days annually or an economic loss of \$360,000,000, on a basis of \$600 annual income. This provides a new and ever-growing field of endeavor which the profession has not yet begun to realize to its fullest extent. There is need of the development of more particular knowledge in occupational diseases and improvement in the practice of industrial surgery. The reconstruction of the crippled is the most valuable service which the profession can contribute to the problems of the future. There will be men known as industrial surgeons in the years to come, and special courses of training will be provided in our colleges to encourage wider knowledge in the functional restorations of the disabled and the reconstruction of the crippled. The nation and state should provide institutions where these men who have been producers of wealth and become seriously handicapped in the midst of their active life, and heretofore have been scrapped as a permanent liability, may be cared for as a state duty and restored as far as possible to a life of continued usefulness and independence. It will be the duty of the profession to stimulate this idea of social justice to the wealth-producing element of our population. The profession must take up the subject of occupational and vocational therapy, whereby the unfortunate may be advised as to the best means of securing functional restoration and employing its remnants to the best advantage in a new field of activity. Already schools of this character have been established in the West and a similar enterprise is about to be launched in New York City, to be affiliated with Columbia College. I have only time to mention occupational therapy as applied to the larger class of chronic systemic diseases, tuberculosis, during the progress of the active conditions, as a means of aiding the arrest of the process.

The evolution and progress of the medical profession in the last three centuries involves the story of the rise from a common, even menial position in society, as it existed in the reign of the first Stuart

King, to one of growing and even commanding importance in the affairs of the world to-day. One has but to survey the field occupied by the doctors of 1619, whose highest privilege was to become a member of the guild of barber-surgeons and to practice their principal talents in the art of blood-letting, and to compare it with the exalted position of the profession in 1919. I never pass a barber's pole without thinking of the depth from which the modern fraternity has emerged. It was scarcely, if any, better than that of the clerical calling so vividly described by Macaulay in his "Review of the Social Conditions" in England in the reign of the son of the first Stuart. Then the parish vicar felt honored to dine in the kitchen of the country squire, and fortunate if he could marry the butcher's daughter. While I do not wish to unduly demean the humble position of the barber-surgeon of the times of the Tudors and Stuarts, I doubt if he were even so pleasantly classed as his clerical brother. The scientific standing of the profession then was not far removed from the superstitions and mysteries of that day. We had not yet been told by Harvey that the blood circulated. We all know that even kings butted into our prerogatives and professed to cure scrofula by the royal touch. This is not a pleasant picture to hold up to ourselves unless we can truly assess the values of our upward progress during the intervening years. From the time when we were sought as necessary evils to perform trivial operations and manipulations, and administer draughts and apply clysters to this day when the profession is sought in council by the public as its most valuable. The day is not far off when the profession will be seated at the Cabinet table of the President taking its place beside those who have interests of lesser importance to the body politic than our own. This consummation has been needlessly delayed because of the lack of interest in the profession itself in obtaining this recognition. It will be a development along the lines of preventive medicine and the conservation of the greatest and best product of our national life—the health of the people. The high road of endeavor lies before us and we may not view the beckonings successfully unless our angle of vision rises higher than the horizontal of past accomplishments. We need to lift our eyes to the purposeful heights beyond in order to achieve the noble mission to which our lives individually and the profession collectively have been consecrated. The glorious altruism of the medical world in the past will find even a more fruitful heritage in the future and much of the uplift of civilization in the generations to come will be molded in the hollowed hands of the thinkers and leaders who will honor our guild in the years to come as the thinkers and doers have brought it ever increasing credit

in the past. But to do this we must go into the work, not only with our minds centered on it, but it must engage the interest of our hearts in its accomplishment. If the mind only be enlisted we shall do a technical job, but if the spirit dwell in our midst as we approach the task before us, we cannot fail. "As a man thinketh in his heart so is he." The future holds the wreaths for the forward-looking men whose hearts and minds work in unison for the common good of our beloved country.

HEALTH INSURANCE.

A development, which the profession has faced in experimental fields in other countries of recent years, must be breasted by the fraternity in this land of ours and it must be met frankly and fearlessly. Every measure that may affect the quality and extent of service or that has potential value in the prevention of disease is of immediate personal and professional concern to us as citizens and physicians. I refer in this connection to the existing attempts of other peoples to provide a health insurance for the masses and to the various projects suggested by the state and national health authorities to meet this growing demand of an influential part of the thinking public. In fundamental ways all these proposals will modify existing conditions in the practice of medicine and involve the social efficiency of all classes who are engaged in the work of conserving the health of individuals and of communities. The term health insurance is essentially the equivalent of the term sickness insurance with some additional features. Sickness insurance is a method by which the economic loss caused by illness is distributed among a group of persons through the payment of periodic assessments by members of the group. This is now provided in the United States as a commercial venture by many insurance companies and by thousands of fraternal orders and benefit associations. In the principal European countries sickness insurance of wage earners has become a governmental function, with this difference, that *all* wage earners are included upon a compulsory basis and the costs of hospitalization and compensation for loss of wages is further distributed between the employers and the public at large. The proposals for governmental health insurance in this country as presented in various forms by the proponents include generally the features just mentioned, but ask for additional benefits. Among these are adequate medical service for the insured and recognition of the logical connection between a health insurance system and existing and contemplated provisions for the prevention of the dissemination of disease. In this sense sickness insurance would become in reality not only a health insurance but a vital health measure.

What effect will these developments, when adopted, have upon the profession at large and upon the individual work of the practicing physician? The answer to this is vital and at once engages all the components of our relations to the general public and to the individual. The question of adequate medical service has become a serious economic problem.

The historical relation of the medical profession to the public in the past has been post-ventional rather than preventional. We have afforded the most complete illustration of standing around waiting to be called to lock the stable door after the horse has been stolen. It had never occurred to the public to anticipate the theft of the animal by utilizing the medical knowledge to circumvent the work of the thief. The profession has spent itself in curative measures only for centuries past, and the public has supported us in that relationship. We have made advances but slowly in the line of preventive medicine. And yet we have progressed, and are progressing, as the public becomes educated to the necessity and value of a conservation of human health as our greatest national asset. It is one of the strange psychologies of our people that they have been so slow to interest in their own physical welfare. Millions have preferred to trust to obtaining health from a bottle at \$1.00 per bottle, or six for \$5.00, as the patent medicine fakirs tempt them, rather than to secure it by obeying natural and scientific laws. To a great extent the medical profession itself is responsible for these beliefs, that health can be swallowed from a bottle of medicine, or built up by the consumption of powders and pellets. Potions in bottles, and pills in boxes have their place in the armamentarium of the physician, but they are the last word, and not the first, which the profession should speak to the public which looks to it for instruction. The medical profession now owes it to the public to eliminate this ancient and fundamental error.

This fundamental error has the inherent unsoundness of an economic error, for the income of the physician is dependent upon the misfortune of his clients. When his patrons are not ill his income dwindles or stops. When they are sick they are without income and become further burdened with the cost of the doctor's services. Under our present methods the profession places a premium upon poor health and paradoxically the patron who is oftenest sick or for long periods is worth more to the physician theoretically than the patient who is seldom sick. To get paper proof of this we need only to examine the ledgers of the profession. To obtain practical disproof one needs only to consider the profit and loss account at every year's close. This situation ought to be reversed and the premium placed on health,

which in essence is the scheme of the immortal Chinese plan, so frequently referred to in every collection of quips and jibes aimed at the "Medicine Man." I recall a personal application of this. Many years ago, when I was stationed on the Pacific Coast, I was engaged by a representative of the Six (Chinese) Companies to perform an operation upon one of their coolies. For reasons not necessary to specify, "Wun Lung" departed to his Celestial Ancestors. The agent refused to pay my account for services rendered on the ground that they had lost a coolie, and their logic was so convincing and the facts so indisputable that I could not overcome his strange philosophy. The end result was that the coolie not only went to heaven, as I assume, but my bill went to hell.

With a premium on health payable to the doctor it ought to be practical to work out a plan by which all the better features of present methods of practice may be retained and at the same time add an economic incentive to the physician to keep his patrons well or to cure them as quickly as possible when they fall sick. Sickness insurance, as we have understood it, will then become insurance of health on a true economic basis.

Adequate, efficient, as well as honest medical and surgical service is not possible, however, without adequate remuneration. The plan which reduces the average income of the physician will fail to secure these three necessary features. The present relationships which exist between the industrial employer, the commercial insurance companies, the compensation commissions and the physician, in so far as the pay for his services by these bodies is concerned, must be revised in the interest of fairness to the wage earner. The physician acts too often as the agent of his employer, the company, to the detriment of the unfortunate wage earner suffering from injury or disease. This is one of the numerous adjustments necessary to be considered if we adopt health insurance as one of the answers to our numerous social problems which must be solved. The inevitable tendency under our present practice is to cultivate the wealthy client for obvious reasons, and perhaps the most ungracious thing the physician does is to refuse his services when the prospect of pay is poor. We need sometimes to consider ourselves in retrospect and the present era is one in which we not only need to do this but must do it.

The experience of other countries in governmental sickness insurance and the experience of this country in the administration of the Workmen's Compensation Law affords the profession ample warning of the shoals and quicksands over which it must travel if the problem of health insurance is to be more successfully managed among us. We

should avoid the indifference and inaction of the medical profession in Germany and Great Britain while their laws were being enacted and thus avert a doctor's strike such as Germany encountered and a near-strike of the profession which followed legislation in England. We should, as the principal administrative factors of any proposed legislation of this character, take an active and public-spirited attitude in an endeavor to produce legal enactments as perfect as humanly possible.

Under the British law, following a year's experience, Mr. Lloyd George announced that there had been an average increase in the annual income of the twenty-two thousand (22,000) who had been registered on the Panels of \$750, and that but 3,000 physicians had failed to be listed as examiners on the insurance Panels. While these laws have not been entirely satisfactory in the fulfillment of hopes, yet it is safe to say that there will be no steps backward along these lines. With the inevitable enactment of the constitutional amendment for women's suffrage the demand for this type of social legislation will be more insistent, including maternity benefits, and the profession should direct all its efforts towards working out practical readjustments rather than endeavoring to render them inoperative by post-legislative opposition.

I have dwelt upon this somewhat at length as one of the shadows cast by coming events which particularly obscures the medical horizon, and I will only further briefly touch upon the features of some of the plans which relate to medical co-operation in health insurance.

1. The establishment of Panels for the listing of licensed practitioners, so desiring to register, who are to be paid upon a capitation or fee basis or a combination of the two.

2. Contract physicians employed upon an annual salary basis from which the insured may select.

3. District physicians paid on a part-time basis.

4. Combinations of various characters of the three previous numbers.

The success of any of these plans will depend upon their administration and in this administration the profession should have adequate representation both in an advisory and administrative capacity.

The usual objection to contract practice will inevitably arise, with all of its known evils, but if the contract is sufficiently remunerative, so that the physician can render adequate service without slighting his patients, much of the objection would be removed. Contract practice is in successful operation in the government services and in many large industrial establishments. In any plan freedom of choice must be fully provided to meet our conception of individual liberty, even

though this exercise of choice is made by the patient to his own detriment. Much can be said in favor of this selective system. The efficacy of any treatment depends upon the mental attitude of the patient toward his medical advisor. This plan would also tend to perpetuate the time-honored relation of the family physician to his patient and further the incentive of every physician chosen by the patient to please his client.

These are some of the problems ahead of us in the reconstructive period. Others I have not touched lest this address degenerate into an Homeric Catalogue of ships launched or on the ways. If this were an oration it might go the limit of endurance, but being only an informal talk, it is time to turn the hour glass.

Necrology.

JOHN AUGUSTUS DONOVAN.

1841-1919.

John Augustus Donovan, of Lewiston, a former distinguished member and in 1897 president of the Maine Medical Association, was leaving the Roman Catholic Church of St. Patrick, in which he had



been worshipping and confessing, on Thursday morning, May 22, 1919, but on reaching his motor car at the edge of the sidewalk he was seen to fall with tremendous violence against the curbstone. Although he was momentarily assisted to his feet by bystanders, he instantaneously collapsed in death. He may have been injured by the fall, but he probably died from a sudden attack of apoplexy and his labors had ceased.

His sudden death at an advanced age may not have been unexpected, but coming as it did it was a terrible shock to his immediate

family, and to his many friends it emphasized the tremendous uncertainty of life. As has been said in the ages past, "Now we are here, now we are dead and gone."

Dr. Donovan, the son of Jeremiah and Anne Crimiles Donovan, was born in Houlton, August 1, 1841, and after studying at Houlton Academy, Woodstock Latin School in New Brunswick and St. Dunstan's College, also in that province, he obtained his medical degree at the New York University Medical School in 1866. He settled at once in Lewiston, but merely by accident, and practiced there for fifty-three years.

During this long period he visited the post graduate schools in New York and made an extensive visit amongst European hospitals. In this way he kept his medical and surgical knowledge at a high pitch of excellence. He belonged to many medical societies, was on the surgical staff of the Central Maine Hospital for several years, and later on the consulting staff, in which position his opinions were highly regarded as for the benefit of his patients. He was for a long time on the Board of Medical Examiners for the county, was president of the County Medical Society and served one term in the House of Representatives, where he did good, watchful and capable medical service for the state. According to all accounts he was an efficient physician and surgeon, as well as an eye and ear specialist, while his surgical results were excellent in his hospital and private practice.

Dr. Donovan was a man of strong likes and dislikes and very outspoken. I well remember his scolding a patient for consulting me, "a mere boy like that" was his expression, but in later years he changed his opinion verbally. It was said of him that he never intruded upon the practice of another physician, or said anything that could be construed as derogatory to their skill. As a member of our association he was for years a shining light, always on hand, always discussing papers, and for some years he presented many very well-sustained, forcible and significant papers, amongst the titles of which I find in the Transactions, "Iritis," "Otitic Meningitis," "Tumor of the Kidney" and "Pleuro Pneumonia," a brilliant paper on "The Uses and Injuries of the Hand," and a fine essay entitled "Medical Hints for Younger Members." His style in papers was excellent, his logic permeating, his ability as a writer of medical papers undisputed. In his presidential address he covered eloquently the entire field of state and social medicine, and was particularly strong in his sarcastic denunciation of physicians who fostered malpractice suits against fellow practitioners, or who testified in the courts against them. How he carried out these beneficial teachings to the utmost

of his ability the records of the courts of Maine will testify abundantly to the medical investigator and historian.

Dr. Donovan lived into his seventy-eighth year, and by his sudden death, after fifty-three years of practice in Lewiston, he carried with him into eternity an enormous sum of public sympathy, for he was undoubtedly a famous physician in the community in which he had practiced so long and so successfully.

He was twice married, first to Miss Jane Sullivan, of Lewiston, and later to Miss Kate Joyce, of Lewiston also, and he is survived by her and by two sons, one a physician and the other a dentist.

J. A. S.

PEARL TENNEY HASKELL.

1868-1919.

If a pet phrase of the twentieth century, "See Haskell," had been in vogue at the end of the nineteenth, when our comrade in medicine was at Bowdoin, it would most certainly have been hung over his dormitory door, for upon no other man in his class were more frequent demands made, when in times of stress his classmates were in need of help, sympathy, advice or consolation. When anybody was in trouble he knew that Haskell would help him out, for he was called the father of the class. "Ask Haskell, he will put you straight and see you through." This same kindness of heart characterized his entire life.

Dr. Haskell, the son of Rev. William H. and Ellen Cary Haskell, was born at Woodfords, Me., March 10, 1868, and was named after an intimate friend of the family, Capt. John Pearl Tenney, a shipmaster of Portland. Young Haskell's early life was spent at Falmouth, near Portland, where his parents removed when he was an infant. After a common school education there he studied at Phillips Andover and Sheffield Scientific, but finally finding his vocation in medicine he attended medical lectures at Bowdoin, and was graduated there in 1893. During all of his student life he was devoted to football and other sports, but not to excess.

He located for practice in Wakefield, N. H., a large township with two centers of population, Union and Sanbornville, in each of which he practiced in succession. In 1905 he was invited to become an assistant at the New Hampshire State Hospital, in which position he remained until 1914. During this time he was a member of the Legislature, suggesting useful medical improvements, and likewise suffered from a long and serious attack of disease of the sacro-iliac

joint, and also of typhoid, which with its sequelæ followed him for many months.

In 1914 he came highly recommended from New Hampshire to be assistant at the Eastern Maine State Hospital, and in 1917, upon the resignation of the lamented Dr. Hills, he was promoted to the superintendency of that excellent institution.

He observed in his service at Bangor that many non-tuberculous patients were being sent into the tuberculosis ward for forced feeding, so he established a tuberculosis ward for the insane alone, and into it in due season many from Augusta were removed. Another aim of



his was to amuse his patients, and for that purpose he organized a minstrel entertainment and a band, for concert purposes as well as for noting the effect of music on the insane. He had no real scientific training in insanity, but he knew how to handle the insane, treating them like big children. He did away with the custom of the internes performing all of the surgical operations, and obtained for this work the ablest surgeons in Bangor. He opened an out-patient clinic for the insane in Bangor, and made it a public value. Finally, as superintendent, he was firm, saw that his orders were carried out, but there were innumerable small items of labor which he did himself

rather than to trouble his assistants. With such infinite pains for small things he soon was overworked.

Dr. Haskell was not much given to the writing of medical papers, although he wrote one of public value, on "The Care of the Feeble Minded," which he read before popular audiences. He was also preparing at the time of his death another, on "The Care of the Insane," for the University Club at Orono. His mind, however, did not run so much on a written expression of his thoughts as on practical results to be obtained from their experimental valuation in actual cases of insanity.

From the beginning to the end of his medical life he kept one aim in view, to alleviate the sufferings and the sorrows of patients. It is related of him in this respect that once upon a time, before the day of the motor car, he drove sixteen miles each way, out and back, for six weeks daily, in all sorts of weather, simply to cheer a patient, although from such a case as that he knew that there would be no pay in the ordinary sense of the word except that of doing a kindness for a suffering patient and friend. Infinite, finally, were his kindnesses to the mentally defective under his care, off and on, for fourteen years of his life.

Up to the last day of his life he worked mostly for others. On Sunday, April 13, 1919, he went to his garage to start off on an errand, but not returning by sunset search was made for him, and he was found dead near his motor car. Although apparently asphyxiated, it seemed more probable to those acquainted with his physical condition that there was an element of myocarditis in his death. In a moment he must have sped along, in the midst of apparently perfect health and as if ready for many more years of kindheartedness to those around him.

Dr. Haskell was early married to Miss Marietta Blake, of Wakefield, who survives him. He was a big, generous-hearted, manly and kind practitioner of medicine and alienist, and his memory will long remain with those who knew him best and most intimately. Truly, he left a host of admirers and friends.

J. A. S.

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*Editorial Comment.***INFLUENZA AND THE STATE BOARD OF HEALTH.**

The JOURNAL has received, in common with all other physicians in the state, a valuable bulletin concerning the chances of the people suffering from another epidemic of this damaging disease, and is following up the bulletin with the suggestion that every physician do his plain duty and hand in a reply card at once. The longer any one waits in answering, the longer the sum total of the work of prevention to be done has to wait. The idea is that physicians should be sure to report their cases at once, treat them energetically and hopefully at once, and insist upon proper and immediate isolation when possible and as early as possible.

The most important question in the questionnaire herewith sent out is just what each physician is willing to do as a temporary public health physician. It is to be hoped that a large percentage of the younger men will volunteer with alacrity and give of their time abundantly. The reward for all such work is always small, except in the consciousness of having done what was good for the state, never mind how little may be thought of it when it is in doing, or when it has been fully accomplished. Physicians have always been ready for sacrifices, and if a fresh epidemic of influenza should come down upon us, there is the same certainty as of old, that plenty of recruits from the ranks of the able-bodied physicians of Maine will be on hand for the emergency.

By the time that this reaches print every physician should have handed in his response to the State Board of Health at Augusta. This is merely to emphasize the call, and to spur on the forgetful.

YOUR COUNTY SOCIETY.

Physicians must never forget that, although they generally lead an altruistic life, they have some consideration remaining perpetually due to their families. Only by forming some kind of an organization can the profession hold its own against the invasions of health insurance, malpractice suits, and so on, items threatening daily the ways and means of living of every member of the profession. One way in which we can organize is as in the state society, but that is oftentimes unwieldy by its large numbers. Then, again, many men will not belong from various selfish reasons. So, too, the county societies are not filled with members, from reasons into which it is needless to enter. One of them seems to be that nobody gets the worth of his money from the meetings. All of these objections would sink into insignificance if every one looked at such societies as unions of to-day, as unions into which laborers and men and women in a vast number of employments are daily flocking for mutual support.

The only real way in which physicians can organize reasonably and with great security for obtaining what they want, lies in the county society. Get good officers and maintain a capable secretary just as long as he can be made possibly to serve, give him something for his labors to get the men together and to keep them together, and in association with the other proper officers to get up a good program.

The writing of papers that shall be satisfactory for listeners is a task to which many men of skill, otherwise, often prove unequal in the highest degree. For that reason the men who can write should be assigned to that part of the program, and the men of wide practice should be the ones chosen to speak of the patients whom they have lately treated. If otherwise—the men who can write are looked to for cases, and the men who cannot write are looked to for papers—the county society does not go ahead, or help the other counties in the state to back up the state association as a labor union of physicians.

THE ADDRESS OF ASSISTANT SURGEON GENERAL CHARLES E. BANKS, P. H. S.

We are glad to have the pleasure of presenting in the current number of the JOURNAL, this valuable and exceedingly interesting address on the conditions in the medical world following the great

war through which we have just passed. Although little of it came under our personal notice, except in the absence of many of our members, most of its effects are gradually presenting themselves for notice and calling for proper consideration from our association.

After a felicitous introduction on his return to the state in which he labored in the field of public health in the past, the writer goes into the results produced by examination of recruits, and thence to the needs of the profession, notably group practice, a medical corporation, each one doing his share and partaking of the benefits according to his skill and results combined.

To our mind, this grouping of men is inevitable in the future, but it can only be managed in large centres of population, so that outside of those the general practitioner will always find enough to do. Owing, however, to the competition of telephone calls for patients to go to the groups, or from motor car calls from men composing it out into the country, the general practitioner will have to be an abler man than of old in many ways.

Speaking of the mentally incapacitated, Colonel Banks urges that many of those so afflicted can be cured by surgery, and having now discovered them in recruits, or those produced by the war, it becomes a problem of after-the-war medicine to study such unfortunates and to make good citizens out of them. In other words, psychosis, in its wide developments, becomes more and more a necessary study by physicians.

The physically degenerate and those under the endless influence of syphilis come in next for suggestive remarks from the writer. Industrial medicine follows in the list of topics then discussed, and plans for safety first and better surgery afterward are laid down in plain language.

Finally, Colonel Banks goes into detail concerning the vexed problem of health insurance, believes that it has got to come and will have to be accepted, but that physicians must wage an earnest fight for higher wages and free choice of physicians.

While we agree with many of the suggestions offered, we believe that although health insurance can be effected fairly well in large centres of population, we cannot grant its efficacy in scattered populations. All that the studious man has to do from this point of view is to read the bitter dissatisfaction with rural panels in Great Britain, and to see that the problem of the country panel doctor has by no means yet been solved. Meanwhile, organized labor is working forward to its goal of world domination over unorganized, and if its onward march does not teach the medical profession a wise lesson for

preparedness and organization, nothing can or will. Unfortunately we drift along, each one for himself, and union between members of the profession remains forever a utopia unattainable.

We commend the scholarly address of Colonel Banks most heartily and earnestly to every member of our association as well worth reading, and in fact more than once, for it is not often that a paper with so many suggestive ideas, so plainly expressed, is presented to us for our careful consideration.

THINGS DONE AT THE MICHIGAN STATE MEDICAL MEETING.

The great objection to the old form of printing merely the Transactions of the Maine Medical Association was that this occurred just once a year, and that during the reading of the printed collection the reader thought for a few minutes of the association to which he belonged; for the rest of the year he knew nothing about it and had no relations with the members whatsoever. With the JOURNAL, things have changed for the better and in one way that is for the benefit of the profession, namely, that by the monthly journal he comes into contact with his fellow members regularly twelve times a year, and beyond that learns from the JOURNAL what is going on medically outside of his own state.

Amongst the most important items of medical value herewith brought to the knowledge of every member we print some things that occurred at the Michigan state meeting in August last.

"Resolved: That the Michigan Society is opposed to compulsory health insurance; that all papers read before this society become the property of the state medical journal for publication, and that the writer is entitled to one hundred copies free of charge; that all papers read before the county societies become the property of the county society before which they were read, and shall be made available for publication in the state journal, and that the author be entitled to one hundred reprints free of charge; that the Secretary of the state society submit to the county societies bills for members in the military service, as promised by said societies and that all public and semi-public hospitals be open to any reputable and legally qualified physician and his patients."

A motion embodying these points of possible value to all medical societies was passed unanimously for reference to a special committee to report at the next annual meeting.

Michigan has certainly opened some new views for all physicians, and the question is, shall Maine do anything in these lines of thought?

THE WHISPERED VOICE SOUND AS AN EARLY GUIDE TO THE DIAGNOSIS OF PNEUMONIC CON- SOLIDATION.

Lissner, in the *New York Medical Record*, Sept. 6, suggests that something more is desirable in the diagnosis of pneumonic consolidation than many of the ancient tests with auscultation and voice-listening. Therefore with a view to reducing dangerous movings about of very sick patients, he suggests the utilization of the whispered voice. Whilst experimenting largely in military hospitals he found that many small areas of patchy consolidation, not demonstrable by percussion, and over which bronchial breathing was not to be determined, were brought out and sharply defined by the whispered voice testings. Going on from ring to ring, as marked on the chest wall, various areas of consolidation could be sharply defined and nicely differentiated by the stethoscope thus utilized.

The conclusions of Lissner's paper are, that auscultation is more important than percussion for the early recognition of consolidation; that by it we can diagnosticate pneumonia even in the absence of bronchial breathing and dullness; that the type of the disease may be thus determined, and the line of demarcation between broncho and lobar pneumonia easily and rapidly made. It is not, however, satisfactory in confluent broncho pneumonia. Finally, the whispered voice sound is an aid to the early diagnosis, and of great value, because it promotes early isolation of the patient in the hospital wards.

DANGERS OF LUMBAR PUNCTURE.

We do not know how often this procedure is carried out in Maine, but to judge from the reading of medical journals arriving from all over the nation we believe that it is becoming quite frequent in modern diagnosis as well as in the treatment of many diseases. In a word, it is being overdone, on the basis of belief that it is, practically speaking, free from danger, and that the material which it yields may give information of great value for patients as well as physicians. Having noticed, as the *Medical Record* informs us, that the letting off of the cerebro-spinal fluid in artificial septicæmia in animals is followed by localization of the infection in the meninges, Wegrath and Latham have lately presented their views in the *American Journal of Science*, clviii, 183. Careful reading of their report proves that lumbar puncture should invariably be preceded by blood culture, and if a positive culture is obtained then the lumbar puncture must be avoided unless we take the serious chances of producing meningitis. If a puncture must necessarily be performed under such conditions, then it should be made

with a very small needle and the smallest possible amount of fluid withdrawn. As the *Record* says, it is significant to note that within twenty-four hours after the withdrawal of a fluid practically normal, the meninges may exhibit the lesions of a severe general inflammation and the fluid contain much pus.

MEDICAL DEFENSE IN IOWA.

We borrow from the state journal of Iowa a large amount of an excellent editorial on this important topic, because in time Maine will come to medical defense, and whilst looking at it tentatively, any items bearing upon it will be of infinite value for us in determining just how our forms of carrying it on will have to be manipulated.

The Iowa editorial runs in this shape, somewhat condensed and modified in phraseology.

Some years ago insurance companies were organized for the purpose of protecting physicians against malpractice suits. Some were organized purely for medical defense. Others adopted a malpractice feature, including indemnity for judgments against the physician sued. The attorney general of Iowa decided that insurance which contemplated indemnifying the physician for judgments secured was contrary to public policy. A succeeding attorney general decided that any commercial insurance against malpractice was unlawful, and all licenses were refused to malpractice insuring companies. During the time that such companies were carrying malpractice defense, state medical societies organized medical defense features which have been continued. In no other state except Iowa was commercial malpractice insurance forbidden.

With this interpretation of the law in Iowa physicians became entirely dependent on the efforts of the committee in defending suits against malpractice, and such mutual arrangement was not considered as contrary to the spirit of the Iowa law. At the last legislature a bill was introduced by insurance men making it lawful for any company to organize a form of malpractice defense which might include the payment of judgments rendered by courts or for a settlement in compromise made by the parties interested. The same legislation prohibited the committee of the state medical society from paying judgments or court expenses unless that committee was organized as an insurance company. After consideration it was decided that the maintenance of such an insurance organization would involve expenses contrary to the policy and traditions of our society and it was resolved that we should continue our defense as of old, paying our attorney, but no judgments or compromises.

Under the new law insurance companies are soliciting malpractice insurance amongst physicians. The committee of the state society feel that, with the experience of eleven years, the state society can defend its members more successfully than any company which will be obliged to contend with the prejudices arising from the fact that the physician himself will not have to pay the judgment, but a mere corporation. There has been in the past the feeling that when a controversy arose between a patient and his physician over the treatment of a case, the physician would be tried by a jury as a private individual and so gain some sympathy from them. But when the controversy arose between the patient and his physician and a suit followed, and a judgment was rendered and it became evident that it would be paid by a corporation hired by the physician to pay it, then the effect on the jury would be different.

We are therefore of the opinion that the best interests of the profession will be served by continuing our former medical defense, which involves chiefly the good name of the physician, and by the carrying of insurance by such members as desire particularly to protect themselves against all possible financial loss.

Here ends the Iowa editorial, which enlightens our steps considerably and makes it plain that medical defense is indispensable, backed up by some form of insurance. Possibly in the formation of a fund provided to pay all expenses and all judgments, as already established in various states, lies the true course for the Maine Medical Association to discuss at the annual meeting at Augusta in 1920. Really, how better can we as physicians celebrate the centennial of Maine than by adopting medical defense against malpractice suits, relying on the jury and upon every fellow member to help us out in our embarrassing situation?

THIRD SURVEY OF HOSPITALS.

The third survey of hospitals being made under the auspices of the American Medical Association is now well under way. Through an extensive correspondence and a third questionnaire the Association has collected a mass of information on the subject. Much of this material has been tabulated and forwarded to committees in each state representing the state medical associations. Most of the state committees have arranged definite lines of action and by inspection of the hospitals or by other methods are securing first-hand information by which the data

collected by the Association is being carefully checked. The immediate end sought is to provide a reliable list of hospitals which are in position to furnish a satisfactory intern training. The investigation is not limited to intern hospitals, however, but will cover all institutions, and the data obtained will be useful in any future action which may be taken in classifying hospitals. The work in Maine is in charge of a committee of which Dr. D. A. Robinson, of Bangor, is chairman, and Dr. Addison S. Thayer, Dean, Bowdoin Medical College, Portland, Dr. John Sturgis, Auburn, Dr. O. C. S. Davies, Augusta, and Dr. Parker M. Ward, Houlton, are members. The closer relationship which the hospital now bears to the public in the community which it serves makes it all the more important that the service rendered by it shall be excellent in character.

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Notices.

“WHAT WE KNOW ABOUT CANCER.”

A Handbook for the Medical Profession. Prepared by a committee
of the American Society for the Control of Cancer, American
Medical Associated Press, Chicago, 1918.

The American Society for the Control of Cancer has been in
existence and working effectively for a number of years. The sole
object of the society, at present at least, is the “dissemination of facts
in regard to cancer to the end that its mortality may be reduced by a
wider knowledge of the disease.” The effort represented by the
present pamphlet has perhaps the most far-reaching possibilities for
good of any single attempt to lessen cancer mortality undertaken in
this country.

It is no longer necessary to argue the point that delay is the one
great factor in cancer mortality. At least four-fifths of cancer deaths
could be prevented by early recognition. The conditions necessary
for recognition of cancer in ample time for cure are not ideal, but

distinctly practicable. Public education is one important pathway of improvement, but education of the medical profession itself is of equal if not greater importance. Statistical studies have shown that in the majority of cases the doctor has had the cancer patient "under observation" over a year before efficient curative treatment is instituted. It is needless to state that during this year the majority of cases have changed from curable to incurable. As the pamphlet itself somewhat mildly puts it, "The conditions call for a far keener appreciation of responsibility for the mortality from cancer than now generally exists in the medical profession."

It is not possible here to abstract this pamphlet, which is already so condensed. The general facts concerning cancer are outlined, and then each important type and site of cancer are taken up in detail, and the forms, symptoms, standard treatment and results to be expected are outlined for each type.

The chief point we would make here is that if every medical man would study and seriously apply the teaching in this pamphlet, which he can read in an hour, the question of delay in cancer would be solved in so far as it is referable to the medical profession. The ultimate possible good obtainable from the widespread dissemination of this pamphlet is so great that we would urge every possible means to get it into the hands of as many medical men of all classes as possible. It can be had from the American Medical Association, 535 North Dearborn St., Chicago, for 10 cents. If you are a trained surgeon, get it. It will interest you. If you are further afield, get it, and study and apply it. If you feel misgivings that some of your cases in the past might have been saved had you been more sure and acted more promptly (and who of us does not have such misgivings), get it. It will help you in future cases.

We would especially beg the assistance of boards of health, both state and municipal, and of medical societies in distributing the pamphlet. It can be bought cheaper in quantities and sent out with your other mail matter with almost no extra cost or trouble. When such a simple means for such far-reaching good is in our hands, it is a pity to let it lie neglected.

We beg to announce to the medical profession of the State of Maine the opening of the New England Laboratories at Springfield, Mass. The laboratories will be run and maintained on strictly ethical and scientific lines, and every effort made to maintain a clinical service laboratory in the real meaning of this term. With a well-trained personnel and an equipment complete in every detail, we are prepared

Stanolind

Reg. U. S. Pat. Off.

Surgical Wax

A new dressing for burns, granulations and similar lesions.

Manufactured by the Standard Oil Company of Indiana, and guaranteed by them to be free from deleterious matters, and so packed as to insure it against all contamination.

Stanolind Surgical Wax has a sufficiently low melting point so that when fluid the possibility of burning healthy tissue is precluded.

Its correct ductile and plastic features make it adaptable to surface irregularities without breaking.

When properly applied it adheres closely to sound skin, yet separates readily and without pain from denuded surfaces.

Stanolind Surgical Wax when applied in proper thickness maintains a uniform temperature, promoting rapid cell growth, and assisting nature to make repairs quickly.

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The Standard Oil Company of Indiana guarantees, without qualification, that no purer, no finer, no more carefully prepared petrolatum can be made.

Stanolind Petrolatum is manufactured in five grades, differing one from the other in color only.

Each color, however, has a definite and fixed place in the requirements

of the medical profession.

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"Topaz" Stanolind Petrolatum.

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to perform with promptness, accuracy and dependability any test or reaction you may request.

Specimens may be sent to the laboratories by mail or express, and containers for that purpose will be furnished upon request.

Appreciating that promptness, accuracy and dependability are essential requisites in laboratory work, it will be the policy of the New England Laboratories to make all reports on specimens submitted as promptly as is consistent with accuracy and dependability.

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Director
GEORGE L. SCHADT, M. D.

Telephone
River 368-W.

NOTES.

COUNTY SOCIETIES — HOW TO KILL THEM.

We note from our *California Journal of Medicine* this little squib, which we print in condensed form for the benefit of some of our readers.

Don't come; and if you do come, be late. If it is too hot, too dry, too cold, or anything in the weather is unfavorable, don't come at all. Make a row if you don't get on some committee and when you do get on a committee never attend its meetings. Don't say a word when you are called upon for an opinion. If you happen to go, be sure to find fault with everything. Hold up your dues as long as you can, or, better still, never pay them at all. Never think of asking another doctor to come in and join the society. Never do anything more than you can possibly help to advance the interests of the society, and when some other fellows take off their coats and do things, you just stand up and shout, "This society is run by a clique."

CASTINE GENERAL HOSPITAL.

When our departed friend, Harrison Briggs Webster, was graduated M. D. at Harvard, he hardly thought that he would become famous in a little country village like Castine and be killed in France under shell fire. Such happened, however, to be his life-story. The great thing that he did at Castine was to set up a hospital, which has in these latter days been incorporated as the Castine General Hospital, to perpetuate the work which Dr. Webster began so finely. Dr. H. S. Babcock is medical director and Dr. E. E. Philbrook etherizer.

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are an outward measure of success. Wear them, not only for looks, but for economy.

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Puffed Wheat and Puffed Rice are whole grains steam exploded. Corn Puffs are corn hearts puffed.

The process was invented by Prof. A. P. Anderson, formerly of Columbia University. The object is to blast all food cells for easy, complete digestion.

Ordinary cooking breaks part of the food cells. This process breaks them all. And it makes grain bubbles, thin and flimsy, with a delicious taste.

These delightful grains, cooked, toasted and exploded, are the best-cooked cereals in existence.

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Chicago

**Puffed Wheat
Puffed Rice
Corn Puffs**

It is to be hoped that some memorial tablet will be placed within it as a further memorial to the work of Major Webster, so well begun in Castine, and so gloriously finished overseas.

NEW AND NON-OFFICIAL REMEDIES.

During September the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion with New and Non-official Remedies:

Abbott Laboratories:

Cinchophen—Abbott.

Chlorazene Surgical Gauze.

Gilliland Laboratories:

Typhoid Paratyphoid Bacterial Vaccine (Immunizing)—Gilliland.

Morgenstern & Co.:

Cinchophen—Morgenstern.

Van Dyk & Co.:

Benzyl Alcohol—Van Dyk.

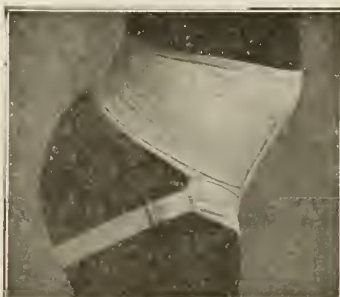
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are especially designed on anatomical and approved orthopedic principles to relieve the cause of the ligamentous strain and correct the abnormal posture. Worn inside the shoes, are comfortable to wear and easily adjustable to meet all conditions as presented to the physician.

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The absence of alcohol or coloring matter of any kind renders it safe and economical and gives the patient and practitioner much more effective Alkaline medication than can be obtained in the ready made liquid compounds. Best results are obtained by dissolving in hot water.

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To meet the requirements of the individual baby, MEAD'S DEXTRI-MALTOSE is made in 3 forms (No. 1, No. 2 and No. 3).

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No. 3. With Potassium Carbonate, 2%—Valuable where constipation is present. Potassium carbonate acts as a corrective by softening the fecal matter.

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INFLUENZA WARNING!

Let's be prepared! At the first indication of return of the influenza epidemic resort immediately to a **PROVEN LINE OF DEFENSE**. Meet the enemy at the port of entry, rendering the upper air passages hostile to his development and you've won the battle.

DICHLORAMINE-T-CHLORCOSANE, Abbott, has proven its ability to protect against infectious diseases originating in the upper air tract, such diseases as meningitis, diphtheria, and influenza.

TO PREVENT INFLUENZA

(1) Spray the nose and throat twice daily with a 2% solution **DICHLORAMINE-T in CHLORCOSANE**, Abbott.

(2) Use **CHLORAZENE**, Abbott, 0.25% solution as a gargle every two hours.

DICHLORAMINE-T, Abbott—powder in one ounce and four ounce bottles.

CHLORCOSANE, Abbott,—in four ounce and sixteen ounce bottles.

CHLORAZENE, Abbott,—tablets of 4.6 gr. each, bottles of 100, 500 and 1000.

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Pituitary Liquid—

is physiologically standardized and is free from preservatives

1 c.c ampoules, boxes of six.

Thromboplastin solution, 25 c. c. vials.

Thyroids—

Standardized. Powder; Tablets, 2 gr., 1 gr., ½ gr. ¼ gr.

Parathyroids—

Powder and Tablets, 1-20 grain.

Pituitary, Anterior—

Powder and Tablets, 2 grain.

Pituitary, Posterior

Powder and Tablets, 1-10 grain.

In a paper on Corpus Luteum in the New York Medical Journal, Dr. Sajous states:

"The two most important prerequisites to success in the use of the drug appear to be:

"1. The selection of a preparation made exclusively from the corpora lutea of pregnant animals, and

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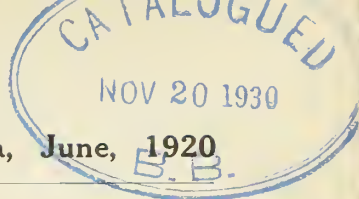
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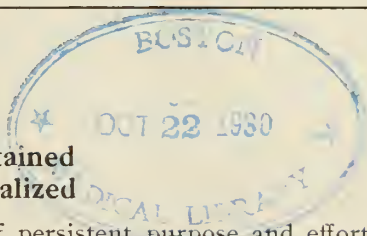
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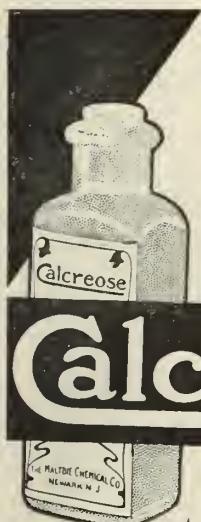
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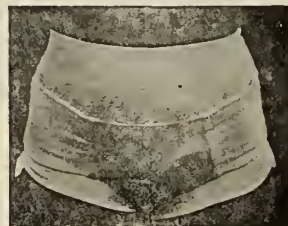


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*"SOCIAL SERVICE IN HOSPITALS."

By DR. R. C. CABOT, Boston, Mass.

LADIES AND GENTLEMEN:—It is twenty-five years this year that I have been working at the Massachusetts General Hospital, and the story that I am to tell this evening is a story of adventure—I might say of conflict sometimes, but of success in the end—in the attempt to so practice medicine that I did not have to be ashamed of myself. The first ten years of my work in the Massachusetts General Hospital left me discouraged. I had been laboring in those ten years to bring up the diagnostic standards of the hospital, and especially of the out-patient or dispensary department where I worked, to bring up their standards to those of private practice. I loved the work, as most doctors do, and I wanted to do a good job for everybody who turned up there. I had plenty of assistants—enthusiastic and great young men. There was no excuse for not doing good work, and I think I can say that in the course of those first years I succeeded in bringing the diagnostic work of that hospital up to the level of private practice, so that one could say that the poor who came there were as carefully studied, as great an effort was made to find out what was the matter with them, as could have been done if they had paid a high fee at a doctor's office. But that very perfection, so far as it was perfection, of diagnosis was just what brought my problem before me. Those of you who are

*Address before the Maine Medical Association, at Frye Hall, Wednesday evening, June 18, 1919. (Stenographic notes.)

familiar, as I imagine you all are, with the problems of the medical profession, know that we are much stronger on diagnosis than we are on treatment. If you watch the amount of time that the doctor spends, for instance, or the amount of interest that exudes from his personality in relation to the sick, it is generally true that he is much more interested in finding out what is the matter, and has a great deal more to say about it, and knows a great deal more about it, than he does when he comes to treatment; but naturally treatment is what interests the patient; and if one has any of the milk of human kindness, if one has any sympathy, one cannot help absorbing from the patient a considerable interest in this branch of his case. Now, treatment, as I faced that problem at the Massachusetts General Hospital, was in at least sixty per cent. of the cases a farce. Why? Well, because we had by that time come to realize clearly that for most diseases we have no drugs that will cure. I assume, tabled more or less according to different standards of classification, there are about, say from 133 to 135 diseases which we have to deal with, and of those I say that there are eight which we really can cure with drugs; the rest we cannot. Now that is familiar, of course, to physicians, and is gradually becoming familiar to the public. (Laughter.) Have we nothing to do for the rest of the diseases that we cannot cure by drugs? Certainly we have; we have a great deal to do. Is it done in such a place as the place where I was working? No; and that is the trouble. I should say that about twenty per cent. of the people that I dealt with there had troubles of their stomachs, or their bowels, or their backs, or their heads, or some part of their anatomy, which, when reduced to their legitimate terms, was nothing but fatigue—tired. If you see a horse dragging a heavy cart up hill, obviously too heavy for him, and very tired, it is not rational to give that horse medicine; you naturally rest the horse if you can. So as we faced our problems with tired people, tired stomachs, tired heads and tired backs, and so on, the problem was, of course, that they should rest; and in my early and innocent days I used to say to these people, "Why, you must take a vacation; what you need is absolute rest." (Laughter.) And I can remember oftentimes I would scold these people and say, "I told you last week when I saw you that you must go away for a vacation; you must take a good rest; you have not done it and it is no use for me to come here if you do not do what I tell you." I did not realize at the time that I was adding insult to injury, that I was telling people to do what they could not possibly do. I did not realize what kind of a fool I was, but it gradually came over me. I remember hearing one man say, as he turned away from one of my

harangues, "Absolute rest! Absolute starvation!" And that was just the fact. Take a vacation! I have often quoted from Alice in Wonderland, where Alice comes to the tea party and the March hare says in a cheerful way, "Have some wine!" And Alice looks around the table and says, "I don't see any wine." "There isn't any," said the March hare. So I said, "Have some rest; take a vacation." "Well, where am I going to get a vacation? There isn't any vacation." "Well, pass along. The next patient will be dealt with." That was the situation. Not incurable disease; perfectly curable disease, but disease incurable by the means that I had to deal out, or anybody at that time had to deal out, in hospitals. I remember a man who came up for examination, and who I found to be very thin, pale, poorly nourished. I examined him as carefully as I could, and did not find anything wrong with any of his organs, and finally I said to him: "I guess you don't eat enough, do you?" He said, "No, I don't." I said, "Well, I will give you something to make you eat," so I took my pad and wrote out a nice prescription and handed it out to him cheerfully and briskly. He hesitated a little before he went off, and I said, "What's the matter? Don't you understand the prescription?" "Yes," he said, "I understand it." "Well," I said, "that will give you an appetite." "Yes," he said, "I see that, but where will I get the food?" He had answered truthfully that he guessed he did not eat enough, and he added a little shock by saying why he did not eat enough — because he had not got the wherewithal to eat. Another patient came on the same day, a woman with diabetes, which is a disease for which we can do absolutely nothing with drugs and a great deal with diet, and we just at that time were feeling very proud of ourselves because we had cut out from the latest book on the subject a very precise diet list, giving for each patient just what he could eat and what he could not eat. We had these on slips of paper bound up into blocks, and I tore off a sheet from this block, with the full list, and handed it to the patient, and, as in the case of the man I have just spoken of, there was a pause as she read it over and saw Brussels sprouts, and one thing and another, on it, and again I realized, a little quicker this time, because of the last patient, what was the trouble. We order vacations when there are no vacations. We order diet they cannot get. We were in a perfectly impossible position. We ordered braces for people's backs and they could not buy the braces. We ordered flat foot appliances for their feet and they could not buy them. We told them not to worry, and there was no conceivable way in which they could stop worrying; they had plenty to worry about. Now, if you think I am overdrawing this picture, go to any hospital dispensary where there is not a social service department, listen to

what goes on, and you will hear things perfectly parallel to what I have been saying to you.

I think perhaps in those days one of the most crying evils, one of the things that troubled me most, was tuberculosis; but that is very much less of a factor anywhere now, because, following the methods which the French invented and then forgot, we are really dealing with tuberculosis now. I think perhaps it is worth your knowing that most of the methods we are now using in tuberculosis are French methods which the French instantly forgot after they invented them and do not carry out in the least degree. They are not doing any good tuberculosis work in France to speak of, although they invented it all, while we are taking their methods and carrying them out, and are now trying to carry them back to France. In relation to tuberculosis in the days that I am describing, in 1895, it was pretty nearly true to say that we were still following the old cynical prescription of a physician who said the treatment of consumption is opium and lies. It was not quite so bad as that, but it was somewhere near, for we had then no tuberculosis sanatoria, and when we would say to these people, "You had better go to Colorado," of course we knew how ridiculous that was before we had said it. Then we went through what I still find going on in parts of the country, what I always call the tractarian era in tuberculosis, when you give out tracts supposed to teach you how you may be saved from tuberculosis by reading what is written on the tract. I do not know whether you have ever been given a tract or been saved by it, but if you have ever tried to radically change any of your habits just as these tracts called for, you know that you cannot change a deep-seated, perhaps life-long habit, merely because you get a little piece of paper handed to you by a man you never saw before. I used to watch the fate of these tracts. Almost half of them were dropped before they got out of the building. Another fraction was crammed into the pocket in a way in which you would be quite sure it was never used for the purpose for which it was meant to be used, and if you watched the people afterwards, followed them up to see whether they actually did the things, you found that practically they never did. Now to carry this matter along a little further, tuberculosis is a disease which certainly, in 70 per cent. of the cases, we know how to cure to-day where people can do what the medical men tell them to do—rest, fresh air, food, all of them costly, all of them out of the reach of the people with whom I was dealing in those days. But even now, when we have sanatoria, when we can supply, as far as the financial side is concerned, rest, fresh air and food, there is a lot more; and just what that residue is I would like to suggest by a story. I was visiting once Dr. Patterson,

at Trimley, England, about an hour outside of London, where Dr. Patterson had then, and doubtless has still, a small sanitarium for tuberculosis patients, I think containing 150 beds, and the patients for that sanitarium were selected by Dr. Patterson from the Brompton Hospital for diseases of the chest, which, if I remember right, had something like 4,000 beds. Out of those 4,000 tuberculosis patients he selected 150 for his hospital, and I was asking him about his method of selection. Of course he could not take everybody, and he had to take the cases most likely to profit by what he had to give. I said to him, "I suppose you pick out the incipient cases, the mildest cases, don't you?" He said, "No, I take some second stage cases, too." I said, "What is your method of selection," and then he said a thing which at the time I thought was cruel, for I did not know him then as well as I did later, and I did not know how much common sense there was in it. He said, in his offhand English way, "Oh, I never try to cure a fool." Now, what Dr. Patterson meant was absolutely right, and it was this: Take two people with an equal amount of tuberculosis and equal resisting power, equal age, equal environment, one with a firm character and one without, the first will get well and the second will die. Patterson knew that better than I did then, and that is what he meant, that he had to take the people who could profit by what his institution had to give. Now what has that to do with social service in hospitals? The social service worker who has had the chance to follow sick people with tuberculosis through the years, see them get well, has got a kind of confidence and a kind of courage which is contagious, and he can hold up the courage of people whose courage tends to fail, and can, I know, save lives by helping people to make their hard, long, discouraging fight, for that is what the cure of tuberculosis is. Now that is one of the places where social service comes in, and always will come in. No matter how adequately we provide for tuberculosis through our sanatoria, no matter even when people do have rest, fresh air and food, they must have courage, and the doctor does not give that commodity away in such doses, or often enough, to keep the patients going. He has too many other things to do. The social worker can do it and does it.

Again, the sanitarium is only a fraction of the solution of the tuberculosis problem, and it never will be more than a fraction of the solution of that problem. Most of the people the most of the time have got to be at home and cured at home, and they can be, provided somebody will take pains about a multitude of details. The cure of tuberculosis is a matter of a multitude of details. You say to the people, "You must eat so and so." For instance, you say, "You must

take six meals a day" when they have not got appetite enough to eat one, and the first time you say it it seems a poor joke and nothing else. If you really make them do it, you have got to go into detail and tell them what is going to compose those meals. You have even got to have something to do with the way those meals are prepared. You tell them they have got to sleep in the back yard or on the roof, and that may be practical and may not. The last time I was at Dr. Trudeau's great sanitarium at Saranac, I asked him about sleeping out-of-doors. He said he thought sleeping outdoors is a very important thing, but he had rather have people sleep indoors than stay awake out-of-doors; that the mechanical forcing of everybody to go to bed out-of-doors does not always result in their sleeping out-of-doors. They are often afraid of the bears, burglars, or all kinds of things, and they do not sleep. Especially is this true if they have not been taught how to make themselves comfortable. A person who is to sleep out-of-doors with tuberculosis, instead of undressing, has got to dress and put on more clothing than he would have on in the daytime, and the bed has got to be made up in the right way and not the wrong way. All these things make a great deal of difference to the persons sleeping in the fresh air. Again, in the matter of rest! We used to tell people how to rest, and visit them and see whether they were resting, and sometimes we would go in and find them in bed. We would notice that they were breathing unusually quickly, and we would think they had fever, and, finding they had no fever and that the pulse was low, we would take the trouble to look under the bedclothes, and would find they had all their clothes on and had jumped into bed when they heard the visitor coming upstairs. There is a very great deal of that sort of thing going on, both among adults and children. The real question is, do you mean business? Do you really mean to keep people well, or are you going through the forms of getting them well? We used to be content with going through the forms. If you are going to deliver the goods, you have got to understand what the doctor wants and see that it is done in detail and for weeks and months. Now, I cannot imagine any more interesting job than that. It is a life-saving job. There are not many of us who can feel that we have saved life. The social worker can, without any false modesty at all.

Now take the problem of children—babies—as they come to the dispensary of any great hospital! Cases naturally come back to my mind, as they impressed themselves most vividly in those early days. I remember that in the month of August, 1904, a baby came into the hospital wards with the ordinary stomach and bowel trouble that babies have in the summer. In the course of six weeks the baby was straight-

ened out, the mother came and carried the baby off, and everything was all right. Three weeks later the baby came back with exactly the same trouble. The hospital, of course, was always ready to take sick people in, and took the baby in. Six weeks in the ward; baby cured again: mother came and got the baby and carried it off. The third time that baby came back with exactly the same trouble. It occurred to me then that the way to get something done in this matter was to touch the pocket nerve. I looked up the exact expense which the hospital had incurred in order to accomplish at the end of three visits of three times six weeks in the hospital precisely the same condition that they had to deal with in the beginning, and I found the hospital spent \$120 to accomplish that result, and when I rubbed that in a little upon the superintendent and trustees they sat up in a way they never had been willing to before that time. Before that they thought my ideas were rather sentimental and unpractical, but when they saw the amount of money they had lost by not being ready to listen to my ideas they then listened. Now that baby's mother was not cruel at all; she was simply generous, large-hearted. Of course, baby came home from the hospital, and the mother, a generous, large-hearted woman, wanted to give it everything that was going, everything there was on the table, and naturally the baby's stomach rebelled. Yet that woman wanted to learn, could learn, did learn. It did not need anything more than teaching, but it needed a good deal more teaching than any of the doctors then in that hospital were inclined to give, because it needed teaching in cooking at the home; it needed teaching in cooking with the utensils that that woman had to cook with. It needed personal influence exerted as it only can be by a person whom the patient feels really cares for him as an individual, and not merely as a patient passing by in the line.

The whole of our treatment of children—the sick children—is a matter of endless detail. It is more true, I think, in that field than in any other. We do not pride ourselves upon our drug treatment. Many people who still believe in drugs for older people will say, "I don't like to give drugs to baby, because they upset his stomach." That appeals to many people when it does not appeal to them for older people. So the problem of the nourishment of the baby, teaching him habits which he must have for his whole life, really does become fairly obvious as soon as one points it out.

Take the problem of babies with heart disease. Young babies — babies under three or four — almost never have heart disease, except the congenital type, which is rare; but the period from, say five to fifteen, especially girl babies, the acquisition of heart disease is tremendously common. Now, we used to say blithely to the mothers of these

babies, "Take the baby home, put him to bed, keep him there three months; that is the right treatment," and it took us a good while to find out that that was absolutely never carried out. Any of you who have had the charge of a lively child, aged somewhere from six to fourteen, know why that treatment is never carried out. These children with heart disease do not feel sick; they have no pain. They have a diseased heart which has got to heal, and if it does not heal at that time right, it will be crippled for life. It may be crippled anyway, but there is a very fair chance that it will not be crippled if it thoroughly heals the first time, and that means, as I have said, months in bed. But when you say to the mother, "Take that child home and put him to bed," she perhaps says nothing the first time. The second time you see her she says, "But he won't stay in bed." That is the attitude, as probably you know, of the average mother when confronted with the desires of her child. What are you going to do? Well, then, somebody else has to take hold and somebody else can take hold. We have one social worker in the Children's Department of the Massachusetts General Hospital who does nothing else but look after babies with heart disease—children with heart disease—and her chief job is to think up games and occupations of one kind and another which will keep the baby quiet in bed. Of course, no intelligent child will stay in bed if you just tell him to go to bed and do nothing about it. You would think little of him if he did. He will certainly get out of bed. If he is occupied in bed, he probably would rather stay there than not. This is a problem that depends on two things, affection and intelligent study, and that is what the case ordinarily does not get. In the first place, the baby has got to be fond of the person who tells him to stay in bed, and in the second place that person has got to amuse his mind as well as his affections, and think up something new quite often for that particular child. Of course, it is not something new every time. We now keep at the Massachusetts General quite a large store of devices—picture books, games, and one thing and another, which have been found to work in this particular problem, and the most of them will still work with a new child.

The old habit of physicians was to treat the individual as an individual unconnected with his family. The old habit of the charities was to treat the individual as a member of a family; and the last is right and the first is wrong. The family as a unit becomes obvious in cases of contagious disease, but it is obvious in many others. When one member of a family has contagious disease, of course we must protect the other members. I can bring this out, I think, by another case which I used as a teaching case in the effort to teach trustees, managers,

committees and superintendents some of the things that they needed to learn. There is a certain family whose name I will not mention, but for convenience I will call them the O'Flahertys, who suffered from a not at all fashionable, but very common, disease, in the West End of Boston, which is known to doctors as scabies, and to the populace as the itch. Now the one thing that is sure about scabies is that it has to be treated as a family problem, and the reason, I imagine you can guess. In the case of the O'Flahertys, at the time the Social Service Department took hold of the problem, there had been eleven members of the family, namely, Mr. O'Flaherty, Mrs. O'Flaherty, and the nine small O'Flahertys, patients at the Out-Patient Department. They had all been there for periods covering about eleven months of the time that I knew the family. They all had scabies at different times. Mr. O'Flaherty came and was treated for scabies in a room at the west end of the building. He went home, and later one of the little O'Flahertys came to the Children's Department at the east end of the building, was treated for scabies and went home. Later, Mrs. O'Flaherty came in and was treated in the female department in the north end of the building, was cured and went home; but they all came back again later with the scabies. Again I figured out the money cost of this family, figuring out what it had been necessary to spend in order to achieve the result at the end of eleven months. There were eleven cases of scabies in the O'Flaherty family, and I found in this case it was \$131.62, that figure having stuck in my mind by reason of the trouble it took us to get the figures. That is what it cost the hospital to achieve the result that at the end of the time the whole family had the disease instead of some of them. (Laughter.) Now, you see what has to be done. You have got to treat the family as a unit. If you ever dealt with charities, you will know that this is an old phrase of the charities, that you must treat the family as a unit. In this case you must make the family a unit. We sent a social worker out in this case and she rounded up the whole family on a Sunday, and, with the assistance of some aunts of the family, treated the whole eleven simultaneously. As they were treated simultaneously, they did not reinfect one another, and, as they did not reinfect one another, they stayed cured, and we watched that family a year to see that they stayed cured, and they did. Now the cost of that cure was the cost of one day's work of one social worker, and a small amount of green soap with some sulphur ointment. That was all that was needed, and yet \$131.62 had been spent, with the result that every member of the family had it. That is easy enough to see when you are dealing with a disease like scabies—anyone can see that—but we have not as a rule even yet, in most hospitals, seen that

in relation to a thing like tuberculosis. You take away the breadwinner of the family and you have got to supply money for the rest, and you have often got to supply something more than money. If the wife of the family leaves home, the husband often does not behave himself, and she sometimes will not leave home because she knows he will not behave himself. She will not go to the sanitarium where you tell her to go and get her lungs cured because she had rather take her chances where she is and not have the family broken up. Then you have got to seriously consider whether breaking up that family is of more importance than the curing of that woman's lungs. If the alternative is not to be accepted, then the kind of social work has got to be put into that family which needs friendship, not to be bought nor easily secured, but is not impossible when you have this extraordinary chance that social work always does give you in extending that friendship. It seems like a miracle to me, but illness is the touch of nature that makes the whole world kin. You know how it is that some families do not always feel themselves very closely kin. They may have words now and then, but if anybody attacks the family from the outside then the family is a unit. So with the human race. When it feels it is attacked from the outside by bacteria, the non-human, then it is drawn together as a unit. The touch of nature in the form of disease makes the whole world kin, and that explains, I think, how easy it is to get on friendly terms with people in social service work. It seems almost too easy sometimes. It seems as if you did not deserve so many chances to make good friends as you have in a place like this, where they cannot help seeing that you have no axe to grind, that you want nothing except what they want, that you are both fighting against the common enemy. That is the greatest formula for friendship that I know of, that you are fighting on the same side against the common enemy, and, when the enemy is disease, you can all do that.

This matter of treating the family as a unit has very wide radiations. Take it in the treatment of syphilis and gonorrhea, for instance. Most people will stop pretty short when they come to face that problem as a family problem, and most people will tell you that it cannot be done. I would have said so if I had not seen it done. Given a man or woman with syphilis or gonorrhea, the only decent thing to do, as I see it, is to get hold of the rest of the family, find out whether or not they are infected, and prevent their infection, and have this done with the advice and consent of the member who comes to you in the first place, as it can be done, because I am doing it all the time. Then good, and only good comes out of it. I know that we have prevented the spread of gonorrhea and the spread of syphilis through a family many times

by this procedure. Of course it is not easy. Of course it cannot be done with the wrong sort of person, but I know it can be done, and I can easily show you that it can be done by the right sort of person, and I do not know a thing more satisfactory than to do something like that.

Now, I have spoken so far wholly of the educational and preventive side of social work, and in many hospitals that is all there is. It does not need to be all. To every large hospital there comes every year somewhere between fifty and one hundred young girls who are facing motherhood without a husband, and the ordinary procedure in those cases is to make a diagnosis, treat them on a purely medical basis, and let it go at that; tell them just what the trouble is, tell them what is going to happen—good morning! When you ask people why they do such things, they say this is not charity, this is a medical institution; this is not an institution for teaching morality, this is an institution to cure disease. But what I see is that by the mere fact that we have told these people what is the matter, we have got ourselves into the middle of a problem which we have no right to stop in the middle of. When you have revealed so terrible a fact as that, with all that it means of shame, of ostracism and misery for years, perhaps for life, you have no right to stop there. Suppose a physician like myself, who does not do surgery, but who specializes in internal medicine, were to see on the fifth of July a boy with a toy pistol wound in his hand, and should say to him, "No, I don't do surgery; there is nothing I can do for you," and stop there! Why, then he might be, as I see it, responsible for giving that boy a case of lockjaw because he did not direct him to the right person, who would have cleaned up that hand and prevented the lockjaw. So, as I see it, with our physicians in our obstetrical clinics—gynecological clinics—at our great hospitals, they must finish up the job as long as they have begun, at least to the point of turning these poor girls over to the people who will look after them, to the right sort of women. They must be in contact with the right sort of a woman, one who is neither too hard nor too soft, who will neither tell her she is eternally damned nor that it is merely a little slip, of no importance, and easily rectified. I have seen both kinds, but there are other kinds. There are women who, taking advantage of the extraordinary chance which this plight, this tragedy, gives them, can become that girl's friend and can help her out of her difficulties—see her through her confinement, see that on the physical side she gets good treatment, which she usually does not, see that she does not go off and have an abortion done, which she otherwise would do in most cases, impress upon her what it is to kill her unborn child and just what she will be doing if she does it,

see that she faces the future with courage because she has got a friend, and see her often through to marriage, as I have seen many women through, with a full knowledge of the facts on the part of their husbands. Now I can only touch there, of course, the surface of a huge and a tragic problem—the problem of sex as I see it in a great hospital—but I say that we who have such opportunities, who are in such strategic positions as we are as physicians, have no right to treat these things on a merely medical basis and stop there; and, if we have no such right, then we must have social workers at hand to whom we can turn for the sort of help that we need.

I have spoken of the physical help and the moral help. There is a great deal to be done in the way of intellectual help that you would not perhaps suspect. Nervous prostration, nervous disease, neurosis, neurasthenia—these things are just as common in the poor as they are in the rich. There are people who have supposed that it was the privilege of the idle rich to have these diseases, and that the poor were too busy. That is not true. The poor have them just as much as the rich. Now these neuroses, about which we only know this, that no organic disease is present—we do not know what they are; we do not know their cause. We do know simply that they have no organic disease. These neuroses, I think, are the cause of the keenest suffering there is in this world. As physicians it is our business to be in contact with suffering year in and year out, and I think most of us physicians agree that mental suffering is the keenest and the worst of any suffering. I have seen people who would say, "Oh, if I only had a good toothache, it would be so much easier than this horrible, haunting, formless terror that I have." Now the doctor's job is not done when he has made a physical diagnosis and found that the heart, lungs and all the other organs are sound. His diagnosis is done, but his treatment has not begun. In the good old days we used to give them bromide, and it certainly is a bromiodism to give that. We now know that that sort of drugs harms these patients and accomplishes nothing, but we also know that they are not incurable, and we have seen many of them come back to full working efficiency. The average organic disease of the heart, lungs, liver or kidneys we cannot cure. We can patch them up for a bit, but we cannot really cure them. But one of these poor neurasthenics, who is perfectly useless, who is a burden to himself and his family, and who cannot earn a cent, under certain conditions we can cure and put back into the working world with happiness and health, but not by medicine or by surgery. Unfortunately, they often get into the hands of surgeons, who invariably make them worse. They can be cured by re-education. They are a bundle of bad habits, and

those bad habits can be overcome, not easily, not without great suffering, but in time, really, they can be taught to control their emotions, and that is what very few of them can do. Very few of us can, but it is possible to learn. These are the most time-consuming of all cases, and the majority of doctors hate them. The state of mind of a majority of the doctors is expressed by a desire to go out the back door when the patient comes in the front. If we see in our morning's mail a letter that looks as though it weighed a ton, we say, "Oh, look! There's another neurasthenic," and when they come to the hospital they bring a list of symptoms written down, and check them off as they go along. Well, those cases take a tremendous amount of time, a tremendous amount of time to hear the story in the first place. It takes one hour on the average to hear a neurasthenic's story for the first time, and then it is not done; but it does them no end of good to tell that story for exactly the same reason that the child who wakes up in the night with the nightmare feels a good deal better when he has told his story to his mother—told it out. Let them tell out the whole of it, even though they can overdue the business, of course, and go on talking about their sufferings too much. Still, once is not too much, and often among the poor there has been nobody who would listen to them before. I have often been the first person to whom they could possibly get a chance to tell their story. I have said that these diseases are just as common to the poor as to the rich, and they are. If you have some visible and tangible ailment it is comprehended among the poor. If you have nothing to show for it, they think you are a fraud and they treat you accordingly. So I think these are the most miserable cases I have seen in hospital work—the neurotic, neurasthenic class of the poor. Now we have social workers specially trained for that job, and I can say that they do as good work as I have ever seen done by doctors, and a great deal better work than I have seen done by most doctors. First, because they have plenty of time—they are paid a salary and they can give whatever time is necessary to these people—and then because I have found that the people who do this work best are generally people who have been neurasthenics themselves and have been cured, and therefore have the sort of sympathy that one cannot have unless one has been through it. I think any person who goes through any such thing ought to feel that he ought to be of use to any poor human being who is going through a like trouble. I am wound up to talk on this subject all night, but I imagine that I had better bring these remarks to a close pretty soon.

I will speak of only one other phase of the work, namely, the work with industrial disease. Now, industrial disease is a phase of medicine coming into great prominence at the present time. We have just begun

to realize that it exists, and now we have got to get to the next stage, which is to realize that it does not exist in the sense that we have supposed. Industrial disease is very rare. Disease in industry is very common, and the making of that apparently purely verbal distinction is an essential thing. Lead poisoning is the only common industrial disease, but there are a great many people in industry who have diseases more or less affected by their particular industry, and the process of disentangling the different factors—work, sleep, worries, diet, home companions and habits, all of which are woven together to make up the disease from which the person suffers—is of that kind that it cannot be done on a large scale nor in a hurry. Like every other part of social work, it is individual. It is the study of a person with the hope of finding out something that you have not found out before, with the confidence that this problem must be different from any other problem because it concerns a different person. We see every now and then in the newspapers wild statements which put back this essential movement against industrial diseases years at a time. You hear people curse the brutal employers who make their employees work under such conditions that they get tuberculosis, for instance. Now tuberculosis is not a disease that you can trace clearly to the industries which we are generally getting indignant about. The relation of tuberculosis to dust, for example, is one of the strangest things in this world. Almost all of us are brought up to believe that dusty trades favor tuberculosis. Now, the facts are these: Steel dust, granite dust, marble dust, certainly do favor tuberculosis, but, curiously enough, coal miners have less tuberculosis than the rest of us. Coal dust is apparently good for the lungs. When you get your lungs good and black, thoroughly saturated with coal dust, that seems to be good for you. Nobody would have believed that had it not been proved. You take the percentage of tuberculosis in the different occupations, and you will find that farmers, gardeners, clergymen and coal miners have the least of it. You can understand the first three, but you cannot understand the fourth. Nevertheless, it is a fact. Then take the dust of fabrics—textiles! Nobody knows today whether that dust has any effect for good or for evil upon the lungs. It may and it may not. Now that sort of study of industrial disease, and of all the factors that enter into it, has got to be made.

I was in Akron, Ohio, a few years ago, at the great Goodrich tire factory, where they employ a great number of men, studying what they are doing there for industrial diseases. I talked with the head of the factory, who brought out this point: He said, "Our men work eight hours. This is an eight-hour plant. They are in this place eight hours; they are out of it sixteen; and we have found that what hap-

pens in the sixteen hours makes a great deal more difference and has a great deal more influence on their health than what happens in the eight." Their conclusion was that they had got to look after the sixteen hours as well as the eight, which was, I think, a very public-spirited, broad-minded conclusion.

Industrial disease naturally links itself up with industrial existence, and industrial existence with the whole problem of reconstruction as we are facing it now after the war. Knowing this, I know how huge is the problem that is facing us in the United States at the present time, and I sometimes feel inclined to think it unsurmountable. I know that the problem of reconstruction must be an individual problem, and I do not see how it is going to be an individual problem on the scale that it has got to be tackled in the United States at the present time. Accident cases—the loss of a leg, for instance, whether shot off in battle or lost in a railway accident—that seems like a good, straight, physical proposition, where all one would have to do would be to find the man a one-legged job. But that is not all. It is largely a psychological job. The one-legged man is met by a conspiracy, quite unconscious, but very effective, on the part of society to demoralize him. The one-legged man as soon as he comes out of the hospital, of course, receives the condolences and congratulations of his friends. Now, I do not know how many of you, especially the men in this audience, have ever gone to pay a visit of condolence to cheer up somebody who needed it: I do not know how large, therefore, may be your vocabulary of condolence, but I do know that the vocabulary of the average man who goes to cheer up somebody who has lost a leg is very limited, and in a vast majority of cases he knows only one method of cheering the spirit, which you can easily imagine, and which I hope will be impossible after the first of July. (Laughter.) But above and beyond that, there still remains this psychological problem of the reconstruction of a person who has lost a leg or some other part of his body, for the friends who cannot cheer him up by "blowing him to a drink" can condole with him, tell him what hard luck he has had, what a pity it was, what a horror he is, how the United States or the "Company" owes him a living for the rest of his life, and gradually get him into the state of mind when for the first time he perceives how pleasant it is to live without working. Now, really and truly, I have seen a lot of men who never made that discovery until they were maimed in an accident, and then discovered that they could live very pleasantly without work. That is what we have got to fight in the first place, and then when they get back into industry, they will find they are going back on even terms. They are going back handicapped, and that handicap is one that they

often need help to overcome. Unless somebody stands by them and gives them the sort of encouragement that they need, the sort of straightening out and talking to that they need, they cannot, perhaps, keep a job. I have found places over and over again for people, and they have lost them over and over again because of discouragement, because they would not mind the rules of the job—all sorts of reasons that would not hold for a person with two legs or two arms. It is a complicated psychological problem. I will not try to illustrate this matter any further. I think you know as well as I can make you see the sort of thing it is. I think of it as a branch of diagnosis and a branch of treatment comparable exactly to what the X-ray gives us. There are facts about our patients that we cannot find out without a home investigation. Our diagnosis is often incomplete, just as it is incomplete without an X-ray picture. You must know that fact. Add it to our other facts, knead it in with all the other facts, and the treatment will often call for the social worker's help as we often call for the X-ray. Social service is a department of the modern hospital for just the same reason as the X-ray is a department of the modern hospital, and the hospital that does not have that is in just the same sort of fix as a hospital without an X-ray plant. We got along very well, the most of us would say, for a long while without the X-ray; so we got along up to 1905 without social service, but anybody who has ever worked for any length of time with the help of the X-ray or with the help of social service will never be content to work without them.

I told you in my opening sentences tonight that it was my own discouragement that drove me into starting social service at the Massachusetts General Hospital. Now, it is not discouraging to work there, because one can see results. Nobody wants to put out his strength and see no results, and we could not see results before we had social service—or in at least 60 per cent. of our cases—and to-day we can. Now that was our small beginning in 1905. Two weeks ago I was at Atlantic City to attend the national meeting of Hospital Social Workers, and we had 361 people there, representing the social work of 141 hospitals in different parts of this country, and the demand for hospital social workers is so great that it far exceeds the supply. To-day, if I knew the right women, I could place them at good salaries in social work in hospitals. Of course, people have first to be born and then to be trained for this job. It is not a question of merely being born, but you have got to be both born and trained.

The last thing I would like to say about this thing before I stop is that, if it ever enters into the minds of any of you that you want to do this thing, either as an amateur, as a volunteer for a part of your time,

or as a public worker for all of your time, I can say this, that I have never seen any body of women so happy in their work as medical social workers as I have seen them in hospitals. Why? Because it brings out everything there is in a good woman. She can use her hands; she can use her head; she can use her heart; she can use the whole of her, and that is all any of us wants, isn't it? We want to be using the whole of us, and this is what social service permits. (Prolonged applause.)

*"THE TEACHING OF SEX HYGIENE."

By DR. W. T. ROWE, Rumford, Me.

While many of us are busily concerned in the stricter regulation of war-time prohibition, in the building of new state roads, in the comparison of the different makes of automobiles, in the various solutions of the terrible and devastating war, and perchance in strictly applying ourselves to our chosen lines of work, how often do we fail to realize that the baby boy of yesterday is fast becoming the young man of to-day, and the curly-headed girl that once toddled at our feet is now a young woman. Too late, perhaps, after some irretrievable error which quickly bows our heads with sorrow, do we realize that we have been unmindful of the welfare of those dearest and sweetest to us. Modern civilization is advancing so swiftly that at times it seems as though we lose sight of the disease, crime and degeneracy about us. We have become so used to them that we have come to look upon them as necessary evils. Modern aircraft, wireless telegraphy, wireless telephony, were things unknown to our grandparents, yet also were eugenics or race-culture, public sanitation, public hygiene and sex hygiene, topics never directly or scientifically considered.

By sex hygiene we mean the health of the species with reference to the sexual relations. We might consider it the fundamental theme of the whole science of eugenics or race-culture. The questions of control and prevention of prostitution, the prevention of venereal diseases and their widespread havoc, medical examination before granting of marriage licenses, the non-sexing of the positively unfit classes by compulsory sterilization and segregation, the elimination of the double standard of sex ethics and morals for men and women, the uniformity

*Read before the Oxford County Medical Meeting.

of marriage and divorce laws—all these essentially have to do with the various aspects of the sexual question.

That there is a crying need for better education in the sex question few will deny. Sex hygiene and social hygiene are inseparable, because of the wide prevalence of venereal diseases. A full discussion of either one is impossible without considering the social evil and disease which it spreads throughout our social system. To those who oppose the light of knowledge being spread upon the ignorance now prevalent in this subject, a few statistics will not be amiss. Gonorrhœa and syphilis are the chief causes of race suicide. Gonorrhea permanently cripples one in one hundred of the population and kills one in two hundred. Twenty to thirty per cent. of blindness is due to gonorrhœa. It was once 80 per cent., but the modern methods of handling the newborn infant have reduced the percentage. It has been estimated that 70 to 85 per cent. of the women operated on for abdominal and pelvic diseases in our hospitals are brought to the operating table by gonorrhœa. Syphilis is responsible for about 90 per cent. of locomotor ataxia, a large percentage of insanity, for a great number of stillborn children, and for a heavy percentage of premature deaths of children, for apoplexy, paralysis, and for sudden death long after the disease was supposed to have been eliminated. Insurance actuaries hold the average syphilis shortens life one-third.

When we consider the enormous prevalence of these diseases, the danger to the public health, the peril to the family, the economic significance and the menace to the vitality, health and physical, and the mental progress of the race, we must feel it high time to put aside our attitude of indifference and work hard to stem the tide. When we are told that the social diseases are responsible for one-eighth of all human suffering and disease, that it is estimated that 60 per cent. of the young men of the United States who reach the age of maturity will at some time be victims of venereal disease, that 50 per cent. of infected women become sterile, how can we justify a policy of silence on this subject? Such statistics would not be possible were it not for profound ignorance on such a subject. It must be granted, then, that there is a great need for the teaching of sex hygiene to the younger generations. Knowledge of this they will and must obtain, and if not from clean and wholesome sources it will be secured from the newspapers, with their lurid accounts of white slavery, prostitution and divorce, from the unrestricted sex plays or sex novels, from the literature of quacks and charlatans, and most frequently from older companions who impart their crude knowledge in most degrading ways.

Ignorance must be dispelled and sex hygiene must be taught. Now when and by whom, you ask? For a working basis, let us divide the

life of the child from birth to adolescence into four periods of five years each. The first period of five years, up to the kindergarten age, belongs of necessity to the parents, and is essentially the time for the moral training. Obedience, general hygiene in regard to cleanliness, air and food lay the foundation for character building of later years. It is the time when physical defects must be righted, and in this regard I firmly believe that all boy babies should be circumcised. The greatest problem at this period is the care of children of the lower classes, especially those of foreigners and also orphans. Much work can and must be done by education of the parents. Our standards of living should be impressed upon them. The brunt of the work in this direction now falls on the social settlement workers, the district nurses, the boards of health or sanitation, and the physician.

The second period, from five to ten, belongs to the schools. A great many object to sex hygiene being taught in the schools. We teach the children to cook and what to wear to be healthy. We even teach how the blood circulates and the food digests, but nothing about the holiest, the most important function of their bodies. Every school-book on physiology stops at the reproductive system. We leave our children to grope in the dark for knowledge of these functions, to pick up a half knowledge wherever they may. Children daily talk to each other about these things and hand on every scrap of information gained. The child must know the dates of every gun fired in a war, the capitals and cities of foreign lands, the products of every country on earth, but this sex knowledge must be gathered on the street. Sex hygiene is the knowledge of how to keep the sex organs in a healthy state. We cannot teach this unless there is some knowledge of their structure and physiology. Before this is possible, we must lay a foundation on which to build this sex knowledge. The teaching of the elementary principles of biology, beginning with the flowers and seeds, fish, continuing later with the birds, and then the life history of the household pets, gives us this foundation. We can show him how nature reproduces everywhere through the intervention of two lives, which by the union of two cells or structures, produces a new one. We can familiarize his mind with the words seed germ and pollen cell, egg cell and sperm cell, baby seed, baby bird, and mother and father bird. This nature study proceeds gradually and naturally to the study of man, and at the age of ten a good foundation has been established. At this time the school teaching should be supplemented in a direct and personal way by the parent or physician. Some authorities recommend this personal instruction at the age of puberty, which in this climate is about the age of fourteen. I believe that every young girl should be instructed at the age of twelve by her mother of the coming change in her life and its tremendous influence on her whole existence. Few girls reach this important stage without having gained some outside knowledge, and how much better it would be if that knowledge be obtained, clothed in clean and wholesome language, from a kind and experienced mother.

During the third period, from ten to fifteen, physiology, animal and human, should be taught, and approaching the end of this period, the instruction in the structure and physiology of the sex organs may be given. The teacher of sex hygiene must have a knowledge of botany, biology and physiology more thorough than can be gained from the ordinary text-book of the schools. He must be a specialist in such knowledge and be specially trained for this work. The one coming nearest to fulfilling such qualifications to-day is the physician. This later knowledge that comes at puberty must be given to the sexes separately. The physician must be one used to dealing with children, and be able to talk simply on such subjects, one pure in mind and heart and with a love for children.

In our fourth and last period, the full story of life should be imparted. Then maternity may be explained to girls with its relation to menstruation. It will not now be difficult for the girl to understand the presence of the ovary with its graafian follicles, and the existence of the room that grows for the reception of the child. The boy will learn that his sperm cells are not to be wasted or improperly used. The evil effects of masturbation may be explained and warned against. He may be taught that the manifestations of action in his genitals are normal, he must be warned against the lure of the charlatan and the faker. The girl may learn the sacredness of her charge; that she must be careful of her egg cells and keep them only for the one who shall be her life partner. Both may learn the sacredness of the marriage relation, the chivalry and care that are due to the woman, the fairness of the father doing his part to support the family, while the mother gives her time to bearing and rearing the children.

I have said nothing about the church thus far, but it can have a strong bearing on the moral character of the child. Morality and sex hygiene are closely allied. Every parent should have his children profess Christianity as soon as possible, no matter what the special form or creed. The influence of the church cannot be overlooked and should be sought at all times.

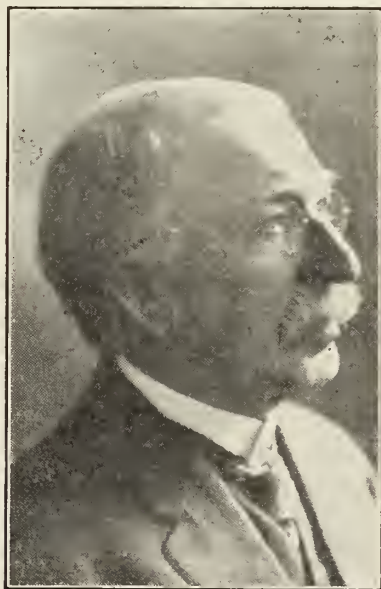
There is a social unrest stirring throughout the country to-day. Social and economic conditions have changed. But shall tradition and custom remain unchanged or adapt themselves to their new environment, their new conditions? Biology teaches us to adapt ourselves to our environment, at the same time endeavoring to change and shape it to suit our needs. To leave the instruction of sex hygiene to later life and often bitter experiences is a sad mistake. Teaching should begin with the early years and continue to adult life. The school, the church, the physician, and the family working hand in hand should be the instructors. The subject must be handled carefully, chastely, and in a refined and scientific spirit. We cannot expect the inertia of tradition and prejudice to yield in a moment. In the past the subject has been generally tabooed. The discussion of sex was considered low, disagreeable and improper. We must do away with false modesty, deceit, hypocrisy maintained by children and parents, and correct the false ideas and ideals which are the inevitable result of our present methods of sex education.

Necrology.

ALBERT GUY HOWARD.

Farmington, 1846-1919.

Although but few of us knew very well this sturdy member of our association, yet he filled in the communities in which he lived and practiced an important place for many years as a genial practitioner of medicine and a good citizen.



He was born in Rangeley Plantation, October 29, 1846, the son of Guy and Mahala Howland Howard. Soon afterward he was taken by his parents to Weld, where he was educated in the common schools and early developed a love for medicine, making a favorite study of books on anatomy. His father, however, was bitterly opposed to any son of his being a doctor, so the young fellow was put to the trade of harness making, opened a shop in Weld, and after a few years moved to the larger center of Farmington. Here our fellow member, Dr. Stanley Perkins Warren, met him, observed the bent of his mind, and urged him to attend lectures on medicine and to sup-

port himself by his trade during vacations. Thus supported, Howard was graduated as honor man in his class at the Medical School of the University of Vermont in 1881, offering for his thesis a paper on "Wilson's Disease," as it may now be called. Oddly enough, this successful theme had been suggested to him not long before by his medical friend already mentioned.

Dr. Howard settled for practice in Cape Elizabeth, with a view of ultimately moving into Portland, but the sea air disagreed with him, so he moved to Kingfield in 1883. A vacancy occurring in the ranks of Farmington physicians he removed thither about 1890, and finished there the rounding out of his practice as well as of his life. He was a sound adviser, careful, kind and conscientious, a good example of the country physician, but he was without that supreme gift of communicating to his comrades in medicine, by means of medical writings or discussions at the county medical meetings, the things that his practice had taught him as well worth knowing. He filled his courteous and agreeable place in the community, people liked him, he did his best always, and accomplished as much by his manners as by medicine.

The death of his wife, born Ella Wilkins, of Farmington, in 1917, caused him deep regret and sorrow, and from that day onward his days were numbered. He abandoned his practice, and gradually passed along, his death occurring Saturday, September 6, 1919.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

SCHOOL EXAMINATIONS; ANOTHER PUSH FORWARD.

We find on our statute books a law that every child in school shall be examined physically at least once a year, provided that the committee is backed up by a vote for money to pay the costs at a town meeting. This is one obstacle in the way, that people are not acquainted with the law. The second obstacle is that nobody wants to spend a cent in any town on anything beyond the mere necessities of life, lest taxes be increased. A third obstacle is that physicians do not seem, like their predecessors, to care to do any work at all for nothing. Altruism is a word unknown to many physicians unless they are urged to make its acquaintance in the dictionary. A final obstacle, as heard in some regions, is that the schools may be public but our children shall not be, just as if children were going to be stripped to see if anything is the matter with them.

Without going into prolonged discussion of these various objections, let us look at the need of such examinations and then propose a simple way out of a dilemma for the present, until the legislature shall be made to see that our school children's examination law shall be compulsory without a loophole.

Forty-five out of every hundred recruits for Maine in the last war were of no use to their state. They might as well have not existed, so far as any defense that they could make against our enemies.

This would not have happened if Maine had done her duty and had her children examined for physical defects at the age when many of them could have been cured.

For that one reason alone we are urging that the physicians everywhere in Maine should offer their services in each town, to show the people just what such examinations are, and let each one of them obtain the composite card shown at the meeting of the Maine Medical Association in 1917. This card is on hand at the Southworth Press in Portland and can be bought at a small price, as we understand, and printed on cardboard of sufficient weight to be durable. Let some smart physician raise the money from the town or from a charity fund and make a beginning, and offer his services just as others have done before. If there are two or more physicians in the town let them get together and divide up the work, or agree that one shall do it this year, and another the next, or in some way make a beginning and get it started. When done, let a report of results be sent in to the JOURNAL and the JOURNAL will make its beginning toward educating the people where enrollment has not been done concerning what has been done in another town.

The JOURNAL is in earnest that the laws of Maine shall be enforced and not turned down by absurd "riders," annulling their valuable provisions, and of all the laws ever passed in Maine that of examination and enrollment of our school children is the most essential, desirable and necessary for the welfare of the state and then for that of the nation, for everywhere, in spite of Leagues of Nations, enemies surround us, and in time to come will again attack us and compel us in self-defence to fight with all the manhood at our command.

EYE SYMPTOMS IN ENCEPHALITIS LETHARGICA.

The JOURNAL printed not long since a paper on this disease, with a case seen in Maine, and from various other later papers on this same disease we note some eye symptoms which may be of value in diagnosing this peculiar affection. In one instance there was upward deviation of both eyes previous to the attack, right pupil very sluggish and left not reacting at all to light, and also there was considerable nystagmus. In another instance double ptosis was noted. Double vision is also a premonitory symptom with some contraction of the fields of vision. In another instance the double vision was found to be due to paralysis of an internal rectus, so that the right eye diverged considerably. Sometimes a loss of central vision is noted, the patient in full consciousness being unable to read, owing to a shadow scotoma before each eye. Some observers have entitled

the eye symptoms as indicative of a toxic ophthalmoplegia. The ophthalmoscopic pictures so far mentioned, in a large number of cases, show no alteration from the normal. Bearing all of these symptoms in mind, it seems advisable that any physician coming across a case of encephalitis should ask in consultation an expert oculist with a view of more precisely differentiating the eye symptoms occurring in this curious disease. So far it seems not to be a poliomyelitis, but what it really is remains problematical.

RAPID DEATH FROM CARBOLIC ACID POISONING.

Surgeon Taylor, U. S. N., reports in the *California State Journal of Medicine* a most extraordinary instance of almost instantaneous death from carbolic acid poisoning, which seems to us well worth noting briefly in the JOURNAL.

A ship's apothecary and an assistant were arranging a large number of bottles of medicine on a set of shelves in a locker in the ship's dispensary. The apothecary was suddenly called to the door by a sailor asking for some medicine. During that time, a period of a very few seconds, his back was turned to the assistant. Hearing almost immediately an unusual sound behind him he turned about sharply, saw the assistant falling to the deck, but caught him before he reached it, then lay him gently down. He called for aid at once, and both the surgeon-in-chief and the assistant surgeon arrived inside of a very brief time. Examining the man they found him insensible, his face pale and pinched, his pulse could not be felt, his pupils were dilated, he gave one or two gasps for air and was dead. There were no convulsions, no vomiting, in point of fact death had been so rapid that there had been no time for symptoms to appear at all. Judging from careful observation and comparison of time it could hardly have been more than three minutes from the moment that the man was left alone standing at the locker before he was dead. There was a strong odor of carbolic acid in the breath exhaled before the man died, but there were no marks on the face or lips. Examination showed on the shelf a pint bottle about two-thirds filled with a liquid labelled "Impure Carbolic Acid, U. S. Naval Laboratory." As no one saw the man drink anything, and as he never spoke, it is natural to infer that at the moment the apothecary's back was turned, the man grabbed a bottle for a drink, and instead of taking it from a bottle of tincture of ginger standing close to that in which the acid was held, he drank from the acid and thus lost his life.

The stomach exhibited the whitening of the mucosa, as in all corrosive poisons, and a chocolate-colored appearance beneath the

surface. The general opinion of the surgeons was that the powerful irritant instantly applied to the stomach mucosa had caused death from shock, just like a tremendous blow over the epigastrium. The sympathetic and pneumogastric were instantly paralyzed, their functions were destroyed, and with that there was instantaneous cessation of vital action in heart, lungs and the brain.

INFLUENCE OF THE WAR ON THE PRACTICE OF MEDICINE AS A BUSINESS.

Under this attractive title, King, of Banning, California, calls attention to some aspects of reconstruction of medical practice after the war, or, really speaking, now that the war has ended. He notes, first, that a good many physicians will now be at work again, and that most of them will practice in their old fields, whilst others will go elsewhere or take up some specialty different from their former general practice. For a time he believes that many of those returning to their former fields will be more than ever popular, but that ultimately each will fall back to his old level, whilst a few will forge ahead as stimulated by war work and practical studies.

He believes that the war will teach doctors and patients that there should be better monetary relations between them than of old. Service to a lawyer or to a business man means money made to show for it. The accumulation of a competence is the public's opinion of every man's industry, frugality or self control. He next mentions three instances in his own knowledge in which physicians died. Two of them, busy men, had saved nothing or made nothing, and were buried by their friends to save a pauper's burial. In the third instance the physician's family was left destitute.

It has lately been claimed, in public, that no physician should earn over \$3,000 a year, and the writer wonders how much of that would pay the overhead yearly expenses of any physician who amounts to anything in the community. Men of the \$3,000 capacity will always be back numbers, with small fees and smaller collections. Yet many with \$5,000, or even \$10,000, a year save nothing.

Physicians should increase their incomes and can if they use common sense. Here is an instance, daily occurring. A physician advises an operation as a case of life or death. The surgeon is chosen by himself, the operation succeeds, the surgeon gets his fee, but the foolish physician sends in an item of a bill for a visit at \$3.00. Now if that physician had written his bill to this effect, "For examination and expert opinion regarding the necessity for a major operation," \$25.00, or even \$50.00, he would have gotten it. He belittled his work, and

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his pay likewise. Call your advice a consultation, and you will get paid for it, when it will be grudged, no matter how small, as a visit. In all consultations, it is ridiculous that the so-called consultant should get his fee of any size from \$50 to \$500 whilst the physician gets oftentimes nothing or a mere visit fee. The consultation fee for two in the same town should be equal, but in case of a man called from a distance the stranger may get much more, but the fee of the family physician should remain always substantial.

Other items in the same direction of thought could be here appended, but enough has been said to show that one of the problems of reconstructive medicine following the war will be for physicians to get higher monetary consideration than ever before. They deserve it. If we, on our side, fail to get what we deserve, we sink to the level of the \$3,000 man, and with that we cannot carry on any medical business respectably, or with a view to saving up something for declining years, when, no matter what your learning, skill or experience, people do not want you. You are never to forget, as you will learn from the lives of the greatest physicians that ever lived, that the moment you retire from the public gaze, even by so much as

resigning or being allowed to resign from any honorary position in medicine, your income cuts itself automatically into half of what it used to be, and age, despite your physical ability or steadiness of hand, soon does the rest. You become a physician marooned upon the island of your own thoughts of former busy hours, filled with patients demanding that advice, which never was half so valuable as it is now, in your age of maturity of experience. Then you were experimenting; now you know.

INFLUENZA QUESTIONNAIRE.

As noted in an editorial published in the JOURNAL for October, 1919, the State Department of Health has recently sent out a questionnaire to all physicians of the state concerning the possible recurrence of epidemic influenza this fall. Dr. L. D. Bristol, State Commissioner of Health, reports to the JOURNAL that such questionnaires were sent to 1,175 physicians in the state, and that up to November, 572 have replied to the questionnaires. From information gathered in the replies from these physicians it has been found that during the last two months there have been only 56 cases of disease resembling the epidemic form of influenza such as appeared last year. These cases are widely scattered throughout the state and no one community reports the disease in epidemic proportion. Five hundred and forty-four physicians have already agreed to co-operate by reporting all cases promptly to their local boards of health. Up to November 4, 288 physicians in various parts of the state had signified their willingness to volunteer for emergency influenza work if they should be called upon by the State Department of Health for such work, the understanding being that during such services these physicians would be placed upon the pay roll of the United States Public Health Service with adequate provision for salary and expenses. In this way the State Commissioner of Health has in hand an emergency corps of physicians to throw into the field should the necessity arise for combatting influenza in epidemic form. In addition to this, Dr. Bristol has obtained the promise from the American Red Cross to supply nursing service in such an emergency if needed, and the Red Cross has already designated Miss Mary Van Zile to direct such nursing work under Dr. Bristol's supervision if it should be required. In the event of a recurrence of epidemic influenza in any community requiring additional medical or nursing service, such communities should correspond direct with Dr. Bristol in regard to the matter. It is sincerely to be hoped that this emergency organization will not be required for service, but the State Department of Health feels that it is its duty to be prepared for a possible outbreak of the disease this fall.

We are very glad to print Dr. Bristol's annotation as above on a possible influenza epidemic, and congratulate the state on being so amply provided for in any possible emergency.

MEETING SECTION OPHTHALMOLOGY AND OTO-LARYNGOLOGY.

In accordance with the call of the secretary the annual meeting of the Section of Ophthalmology and Oto-Laryngology of the Maine Medical Society was held on June 18, 1919, at the Pillsbury House, Pine Point, Maine.

After dinner, Chairman Beach called the meeting to order.

Present: Drs. Moran, Holt, Austin, Bowers, Kerchner, Gilbert, Little, Fisher, Beach, Spalding, and Holt, Jr.

Guests: Drs. Whitney and Gordon.

The records of the previous meeting were read and approved.

Dr. Spalding, as chairman of the conservation of vision, reported that one address to a normal school had been given the past year. Now that the war is over he urged a renewed interest in this work. It was voted to accept the report, place it on file and continue the committee.

Dr. Kerchner, as chairman of the executive committee, said that this section had been temporarily depleted by the war so that it was quite impossible to have meetings. He recommended that the meetings be continued as before the war.

Chairman Beach spoke in regard to conservation of vision and hoped they all would try to interest the public so that better legislation could be obtained in this direction.

Upon motion of Dr. Holt, Jr., it was voted to make Dr. Spalding an honorary member of the section in recognition of his long and useful service as an ophthalmologist.

Dr. Spalding reported a case of extreme disturbance of the nervous system necessitating the use of hypnotics. This condition was relieved quickly and permanently by the removal of inspissated cerumen from the external auditory canal.

Another case ten to twelve degrees hyperphoria due to the same cause. Forty-four hours after its removal no diplopia present.

Third case, a symmetrical cornea at the age of 25, changed to a cornical one after four abscesses of the teeth. Vision now can only be corrected to 20/40.

Election of officers resulted as follows:

Chairman, Dr. Kerchner.

Vice-Chairman, Dr. Gilbert.

Secretary and Treasurer, Dr. Holt, Jr.

Dr. Kerchner presented a carefully prepared paper on "Clinical Observations in the Ophthalmic Service at Camp Sevier, S. C." The whole number of cases treated was 1953 in ten months. In 839 refractive cases 77% were in the hyperopic class and demonstrated that sunlight and wind are factors in bringing out this form of ametropia. There were 741 cases of acute conjunctivitis and the chief offending organisms were the pneumococcus and the Koch-Weeks Bacillus. Phlyctenular conjunctivitis of the usual type was seen in seven cases. In some of the 16 cases of trachoma the Bacillus Bulgaricus treatment

was tried, but was soon displaced by the usual method as it had no beneficial influence on the disease. Twenty-eight cases of squint were operated upon with remarkably good results. In the chronic lachrymal diseases the extirpation of the sac gave better results than the trichloracetic acid method of Gifford. In spite of the high percentage of pneumococic conjunctivitis there was not a single case of ulcer serpens. Neither was interstitial keratitis seen. An interesting and unusual case of disciform keratitis came under observation and treatment. Two cases of injury, one unique in the manner in which the eye was injured, were seen. Both made good recovery. Ocular diseases of dental and naso-pharyngeal origin were carefully studied and about evenly divided between the reflex neuroses and the acute inflammatory processes. In these cases prompt treatment for the eye and for the focus of infection gave gratifying results. Mention was only made of syphilis as a factor of eye diseases, as this subject was being investigated by Capt. J. M. Blackwood. Quite a variety of fundus cases, both active and old, were seen. Malingering was common and was classified as positive when the complaint was manufactured without any basis and negative when a defect was exaggerated. Three to six applications of silver nitrate one to two per cent. usually caused a disappearance of the alleged symptoms. It was not possible to study systematically the eyes of soldiers sent to the nervous and mental departments, on account of the scarcity of ophthalmologists. At present this is being carried out.

At the conclusion of Dr. Kerchner's remarks a rising vote of thanks was given for this most interesting and valuable paper.

Voted to adjourn.

Adjourned.

E. E. HOLT, JR., Sec.

County News and Notes.

CUMBERLAND.

MEDICAL OFFICERS OF THE WORLD WAR.

At a meeting held in the Congress Square Hotel, Nov. 5, 1919, forty medical officers, who had been in active service, organized and adopted a constitution and by-laws.

There are sixty medical men in Cumberland County who served in the war and all are very enthusiastic over the new organization, and look forward to a state body, whose membership will be restricted to medical officers only. Similar organizations have included medical corps men, recreational workers, etc., whereas the membership of this organization "shall be composed of officers of the Medical Corps of the Army and Navy who served in the world war." It shall stand for good government, progress in all medical and health matters and among its purposes it shall perpetuate the loyalty, efficiency and stand-

ards of the Medical Reserve Corps of the Army and Navy; render such aid as is possible in the reorganization of the Medical Reserve Corps of the Army and Navy; hold regular meetings devoted to medical and medico-military subjects; promote good fellowship and comradeship among the medical men in the service.

Among the great lessons brought out by this war was the absolute need of a closer organization and unity of the medical men throughout the country; whereas those men in the service have seen the great value in team work, and what it means, not only to the organization, but to the individual.

The base hospitals not only gave to the sick and wounded soldier the services of specialists in every field of medicine, but gave every specialist the opportunity of calling into consultation any or all others in the study of a given case. When the internist is in doubt in an obscure case, he can sit down at his desk and in a few minutes make out consultation slips for all other departments and hand them to his sergeant. Within twenty-four hours, as a rule, he will have written opinions on his desk signed by the examiners from each department, and if this does not give the internist all that he desires, he can request a joint consultation, or hold frequent conferences with representatives from any department he feels can aid him in the case. Just think what this meant to the soldier and how much to the medical man who had easy access to every possible aid to diagnosis, or the medical man who was compelled to place his opinion in writing, and if necessary, to go into a conference to defend it. Under such an organization he became a keen observer and a diagnostitian, and he soon realized the value of rubbing shoulders with other medical men.

When the medical officer leaves the service for private life, he is not contented with the old order of things. As an individual he cannot change them, but the influence of a good, live organization will be sooner or later felt and appreciated by both the profession and the public, and so the future work of the Medical Officers of the World War finds a definite field of action.

The officers of the organization are as follows:

President, W. L. Cousins, M. D.

First Vice President, T. J. Burrage, M. D.

Second Vice President, T. N. Whittier, M. D.

Secretary, Frank Y. Gilbert, M. D.

Treasurer, Stanwood Fisher, M. D.

EXECUTIVE COUNCIL.

E. G. A. Stetson, M. D., Brunswick.

A. H. Little, M. D., Portland.

Alfred Mitchell, M. D., Portland.

W. Beane Moulton, M. D., Portland.

Carl Robinson, M. D., Portland.

CUMBERLAND COUNTY MEETING.

The 50th stated meeting was held at the Congress Square Hotel, October 24, 1919, at 8 P. M.

The meeting was called to order with Dr. L. B. Hatch, president, in the chair.

There were present 50 members and 10 invited guests.

The records of the previous meeting were read and approved.

There were no case reports.

President Hatch then introduced Lieut.-Col. Thomas J. Burrage, who spoke on the American Base Hospital at Mesves and a unit of it, Base 54, to which he was assigned as medical chief. The location, size, structure, and arrangement of the whole base and a unit of it was clearly depicted, indicating the keenness of Lieut.-Col. Burrage's observation. In each unit there were 36 officers, 5 administrators, 6 internists, 21 surgeons, 2 pathologists, and 2 radiologists.

The most prevalent medical diseases were broncho-pneumonia, meningitis, influenza, rheumatism, gas fever, and typhoid fever. The latter disease, although not common, was probably due to faulty technique in giving the anti-typhoid serum and the superabundance of infection to which all were exposed. As it was a part of his duty to search for medical cases among the surgical ones, it was possible for him to obtain an insight of the accomplishments of the surgeons. The Carrol Dakin treatment of suppurating wounds and the closure of the same by the bacteriological count method were highly mentioned. Another very important trust was placed in him by being chosen chairman of the "Disability Board", which necessitated examining every Class A and D man. This enabled him to study more closely the end results. The work as a whole was arduous, interesting, and accomplished with celerity and efficiency; thus enabling "the boys" to receive the best care and treatment.

Upon motion of Dr. John F. Thompson, a rising vote of thanks was extended to Lieut.-Col. Burrage for this most interesting and instructive presentation of the subject.

Dr. George B. Swasey, of the Board of Censors, moved that Dr. Augustus S. Thayer be placed on the honorary list, and it was so voted.

The following presented certificates of transfer from secretaries of their respective societies stating that they were in good standing. Their names were separately balloted upon and all were elected.

Dr. Harry L. Stilphen, Fairfield County, Bridgeport, Conn.

Dr. L. K. Austin, Kennebec County.

Dr. L. L. Powell, York County.

Dr. E. S. Cummings, Androscoggin County.

Voted to adjourn.

Adjourned.

E. E. HOLT, JR., Sec.

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OXFORD.

OXFORD COUNTY MEDICAL ASSOCIATION.

The annual ladies' night and banquet of the Oxford County Medical Association was held at Bethel Inn, September 29, 1919. The business meeting was called to order by the President, Dr. J. M. Sturtevant, of Dixfield. The application of Dr. W. B. Twaddle, of Bethel, was read and referred to the Board of Censors for the next regular meeting. Dr. Sturtevant called for reports on cases of influenza, and as far as could be ascertained there were no cases in Oxford County this fall. Dr. Olin Pettengill, Superintendent of Hebron Sanatorium, read from his annual report, and his statistics compare favorably with those of the best sanatoria in the country. The meeting was then adjourned to the banquet hall.

After a splendid banquet, the following program was given:

Solo,	Mrs. James M. Sturtevant, Dixfield
Reading,	Mrs. H. L. Bartlett, Norway
Solo,	Miss Frances Wheat, Westbrook
Paper on "Diet,"	Dr. C. M. Bisbee, Rumford
Paper on "Sex Hygiene,"	Dr. W. T. Rowe, Rumford

The following were present: Dr. and Mrs. W. M. Pease, Dr. and Mrs. J. S. Sturtevant, Dr. and Mrs. J. M. Sturtevant, Dixfield; Dr. and Mrs. F. E. Wheeler, West Paris; Dr. and Mrs. C. M. Bisbee, Rumford; Dr. and Mrs. F. E. Wheat, Miss Frances Wheat, Miss Harriet Wheat, Westbrook; Dr. and Mrs. Eugene McCarty, Rumford; Dr. and Mrs. H. R. Farris, Oxford; Dr. and Mrs. D. M. Stewart, South Paris; Dr. and Mrs. Olin Pettengill, Miss Pettengill, Miss Roderick, Hebron; Dr. and Mrs. H. L. Bartlett, Norway; Dr. and Mrs. R. R. Tibbetts, Bethel; Dr. and Mrs. B. F. Bradbury, Togus; Dr. and Mrs. W. T. Rowe, Rumford.

W. T. ROWE, *Sec.*

YORK.

YORK COUNTY MEDICAL SOCIETY.

The ninety-eighth quarterly meeting of the York County Medical Society was held at the courthouse, Alfred, Thursday, October 16th. Dr. Ansel S. Davis, of Springvale, President of the society, was in the chair. Two applications for membership were presented and they were referred to the Board of Censors.

Dinner was enjoyed at the Alfred House.

The afternoon session opened at 2.30 o'clock, with a paper by Dr. Carl G. Dennett, of Saco, the subject being, "A Study of Three Cases of Anthrax with Blood and Bacteriological Findings." This paper was highly instructive and revealed much careful research and scientific attainment. Dr. Dennett was First Lieutenant, M. C., U. S. Army, and was stationed at Camp Dodge, Des Moines, Iowa. This paper of Dr. Dennett's was printed in *The Journal of the American Medical Association*, Jan. 25, 1919, Vol. 72, pp. 270-272.

The second address was by Dr. Thomas Tetreau, of Portland, the subject being, "Some Observations on Rural Sanitation." Dr. Tetreau is the health officer of Portland, and he is well known for his marked ability along all lines of public health work, which is such an important development in this age.

A rising vote of thanks was given both speakers.

There were present the following physicians: Thomas Tetreau, Portland; Ansel S. Davis, Springvale; Harry L.

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YORK COUNTY DAUGHTERS OF HYGIEIA.

The regular meeting of the York County Daughters of Hygieia was held at Alfred, October 16th. The attendance was affected by the weather, the unfavorable clouds of the morning soon bringing rain. Those present were: Mrs. C. F. Kendall, Biddeford; Mrs. S. B. Marshall, Alfred; Mrs. F. W. Smith, York; Mrs. H. L. Prescott, Kennebunkport; Mrs. E. C. Cook, York. Mrs. H. R. Ferris, of Oxford, was the guest of the society.

Mrs. S. B. Marshall welcomed the ladies at the courthouse, where the meeting was held. The chief business discussed was the support, for the next year, of the adopted French orphan of the society, Alice Hygieia Calmels. It was decided, if the necessary funds could be raised, to keep up this work another year.

The members of the York County Daughters of Hygieia, through the MAINE MEDICAL JOURNAL, extend greetings to the medical societies of the counties and would recommend that the wives organize on lines similar to those adopted by the ladies of York County.

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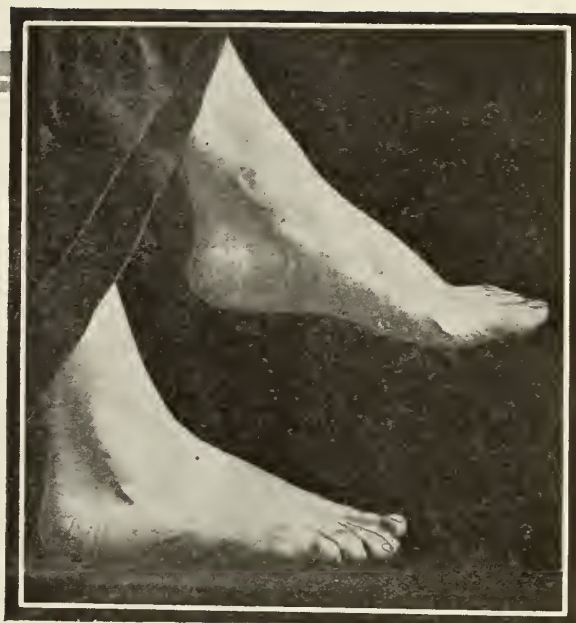
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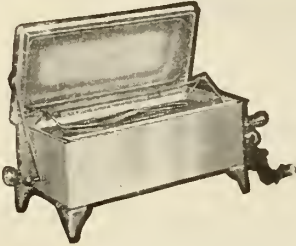
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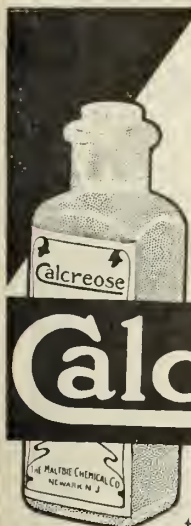
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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. X.

DECEMBER, 1919.

No. 5

***WHAT HAS THE MEDICAL PROFESSION LEARNED BY ITS EXPERIENCES IN THE RECENT WAR?**

By CHANNING FROTHINGHAM, Boston, Mass.

It will be impossible at this time to take up in any detail all the various points of interest to the medical profession that have been brought forward during the recent war, therefore attention will be only briefly called to some of what seem the more interesting developments. In the first place, there are the advances in medicine, surgery, pathology, hygiene, etc., that have appeared from work done by the medical officers. On the other hand, the opportunity to observe the members of the profession in the manner that the army affords has shown certain weaknesses in the profession, many of which are remedial. Finally, opportunity has been given to think over the organization of the army medical corps and to formulate ideas in regard to improvement in it and in the organization for the calling of the physicians of the country into service in case of future need.

Among the advances made in medicine perhaps the most interesting is the discovery of the existence of so many cases of so-called neuro-vascular asthenia. This condition of marked instability of the pulse rate, shortness of breath and general weakness has been studied

* Presented at the Annual Meeting of the Maine Medical Association, June 19, 1919.

in detail by Lewis and his colleagues in England and Peabody and his colleagues at the General Hospital, No. 9, Lakewood, New Jersey. Although this condition simulates in some measure hyperthyroidism, and at times suggests organic heart disease, it is now considered to be some disturbance of the sympathetic nervous system.

Graded exercise and careful routine of life has accomplished much towards returning these patients to normal. By demonstrating that in cerebrospinal meningitis in the early stages the organisms are present in the blood stream, Herrick has emphasized the importance of the intravenous use of anti-meningococcic serum as well as the intraspinal use in the early stages of this disease.

The commission appointed by the American Red Cross Research Committee, and headed by Doctor Richard P. Strong, to study trench fever has presented a splendid report on this disease, in which it makes it clear that the disease is transmitted by the bite of the louse. From their vast experiences with penetrating wounds of the chest, medical officers in France have added considerably to our knowledge of the diagnosis of obscure pulmonary and pleural conditions.

A beginning has been made by Dochez and his colleagues in classifying the streptococcus in the same manner that the pneumococcus has been classified by the workers at the Rockefeller Institute. It is to be hoped, therefore, that in the future it may be possible to produce an antistreptococcus serum which will be of value in the same manner that the antipneumococcus serum is towards the specific strain of the pneumococcus.

Although no definite decision has been reached in regard to the etiology of the epidemic of influenza, and although it is still uncertain whether the influenza organism is the original cause of the epidemic or just one of the complicating factors, considerable advance was made in the study of the complications of this epidemic and in the study of its pathology.

In surgery the ingenious devices planned by the orthopedic surgeons for the fixation of limbs without covering over wounds that needed to be dressed represent a marked advance in this line of work. A tremendous saving in time in the healing of extensive septic wounds has been made by the application of various new methods. Prominent among them is the Carrel-Dakin method. Opportunity has been given for advance in plastic surgery, especially on the face. The large amount of empyema has stimulated interest in the best method for treating this condition, and already several good communications on this subject have appeared in the literature.

It seems possible that a statistical study might be made on the large number of hernia operations that were performed on the men being inducted into the service and considerable light be thrown upon the value of this operation.

The possibility of performing autopsies on all cases in which it was considered necessary by the commanding officers of the various medical establishments made it possible for complete pathological studies on many interesting and important cases. By this excellent rule in regard to autopsies the army has shown that it is possible, without causing any disturbance on the part of the public opinion, to insist upon a post-mortem examination without asking the consent of the relatives of the deceased. Let us hope that civil hospital trustees will profit by this example and insist that a post-mortem examination be done in order to complete the study of any case which has been unfortunate enough to die in their institution.

The instruction in hygiene which has been given to this large number of young men must have a tremendous effect in the future upon their method of living. The advantage of fresh air, pure water and milk has been emphasized. The soldiers have been trained to appreciate the importance of the proper disposal of all secretions and excretions from the body. They have been taught the value of proper care of the teeth.

The importance of inoculation against paratyphoid fever as well as typhoid fever has been brought out by this war so that the practice is rapidly becoming universal. Some advance has also been made on the question of the value of prophylactic inoculations against dysentery and pneumonia.

This war has also emphasized the importance of the louse as a carrier of disease, and methods have been devised for the eradication of lice from large numbers of infected men and clothing.

Perhaps the biggest problem that has been tackled in regard to preventive medicine has been the problem of venereal disease. The insistence upon prophylactic procedure after exposure has had a marked influence in keeping down the incidence of venereal disease among the soldiers. The success in clearing up sources of infection, not only about the camps proper, but also in cities at miles distant, has been a revelation as to the possibilities in that line of work. Such a campaign could easily be waged by civilian health authorities if proper funds were provided. That this work should be organized is evident from the large amount of venereal disease that has been shown to exist among the raw recruits coming to the camps. When one con-

siders the amount of public money that is spent in the fight against tuberculosis, and the practically insignificant amount that is spent in the fight against venereal disease, it shows a relation quite inconsistent with the incidence and importance of the two diseases.

The above has been a short summary of some of the more striking advances in a few of the branches of medicine which have been brought out by the war. Let us now turn our attention to what defects appeared in the medical profession. It must, of course, be appreciated that the ability of doctors varies as the ability of men in other walks of life, and therefore it can hardly be called a defect if all its members do not measure up to the highest grade of ability. On the other hand, there were certain remedial defects in the profession which became quite obvious during the war. It should be our duty to study these and provide for their eradication.

Prominent among these defects noted in the profession was a weakness on general medical knowledge in certain officers, showing that these men had never attended a school in which a good fundamental course in medicine had been given. Another important weakness noted was a marked inability on the part of some doctors to handle new therapeutic agents, or to use the recent advances in diagnosis that have become generally accepted as of value. Furthermore, the average medical man was very slow in the practical application of clinical pathology. It was quite obvious that in many instances the doctors had not been performing or using these tests as much as should be in their private work. There was also a tendency not to exhaust all the possible aids to diagnosis in studying a case. From the difficulty which the medical profession had in mastering the exact method required by the army for the keeping of records it was evident that most of the profession must keep very inexact records in their private work. Another surprising feature was the apparent lack of appreciation on the part of practitioners of what training is necessary to render a man fit to do surgery, for many a doctor on coming into service expressed a desire to do surgical work, although admitting that he had no surgical experience. They did not seem to realize that a thorough apprenticeship as an assistant is required before it is safe for a man to tackle general surgery.

The remedy for the majority of these defects lies in the elimination of poor medical schools from our country. Already a considerable advance in this line has been accomplished within fairly recent years, but there are still a considerable number of schools that ought not be allowed by law to exist with their present standards. The poor schools can be eliminated or forced to improve, both by educating the

public so that it realizes that it makes considerable difference in a man's professional ability whether he has graduated from a good school or not, and by enacting laws that will prevent a man from practicing medicine unless he can fulfill certain requirements of such a nature that they cannot be obtained in these poor schools. The system of requiring permission from the state to practice exists in the various states. Unfortunately the requirements in some states are not sufficiently high to eliminate the poor schools. The medical profession should be continually striving to raise these requirements. In addition to improving the standards in the individual states, it would be well for the medical profession to settle on some general standard which would apply to the whole country, for a considerable hardship is sometimes caused by the fact that the various states have different requirements for the practice of medicine.

The application of new diagnostic aids and the use of new therapy can be brought to practitioners of medicine by means of graduate instruction. This can be accomplished in two ways: the doctor can go to the medical center and there receive his instruction, or the doctors can group themselves and arrange to have the instructors in graduate medicine come to them. This latter plan has the distinct advantages of allowing the busy practitioner to learn about the recent advances in medicine with the minimum loss of his time from his practice. In order to become proficient in clinical pathology a doctor must have actually done the various tests often enough to make the procedures almost reflex actions. Few, if any, medical schools can give the students enough of this work during their four years. The better students get this experience in their internships in hospitals. This is just another argument in favor of demanding a year as an interne in a recognized hospital before one is allowed to practice.

To overcome the tendency to leave out some laboratory procedure that might help in making a more exact diagnosis the profession should train itself and the public to a realization that any error in judgment is sometimes bound to occur, and, therefore, at times permissible, but that the error of omission is inexcusable.

Let us now turn our attention to the army medical corps. With the expansion of this corps to the tremendous extent that was necessary during the war evidences of weaknesses in the organization were bound to appear. The fact that the medical corps at the end of the war was being operated on practically the same lines as were outlined in the medical manual before the war started shows how well the organization had been worked out.

One of the most serious defects in the organization of the medical corps is the use of medical men for administrative work. This recent emergency showed that there are hardly enough physicians to carry on the needs of a huge army and the civilian population, and therefore every physician is needed for the care of the sick and injured. This defect can be easily remedied by the enlargement of the sanitary corps and the application of officers in this sub-division of the medical department for practically all of the administrative offices in the medical department.

There was also too much shifting about of medical officers from one job to another after they were started upon their active service. The result was that a man would learn the details of one part of the medical work only to be suddenly shifted off to some other work and have to then learn another part of the work. As the time is short for learning after one is called into active service, it would be better to classify more thoroughly the medical profession, not only those in the reserve corps, but all who might be called upon, so that one could be promptly started on the job one was to do throughout one's army career. In this way an officer would be better prepared to do his army work in a shorter space of time.

Another weakness in the system as practiced during the war was the method of ranking the medical officers of the regular corps and reserve corps. At first the officers of the regular army outranked those in the reserve of the same grade irrespective of the date of the commission. With the rapid expansion of the corps promotions came quickly and the result was that in some instances rather young officers of the regular army were placed in command over older and broader men in the reserve corps. In some instances the results were not satisfactory. To remedy this, more care should be exercised in the awarding of commissions to the reserve officers, and when the reserve officers are called into active service they should be on an equal footing with the regular army officers, for the lessons to be learned in the army are not so complicated that only a man long trained in the army can master them.

The formation of a group of clinicians, known as consultants in the various branches of medicine, seemed to be a mistake because of the shortage of good clinicians to act as chiefs of the various services in the hospitals. At the time of the armistice there were about three hundred hospitals in this country and abroad. These three hundred hospitals included general hospitals, base hospitals, camp hospitals, Red Cross hospitals, and base hospitals loaned to other countries. There must be enough good clinicians in the various branches of medicine so

that there would be one to take charge of the service in each hospital. Better work should be done with an expert acting as chief of the service and actually taking part in the work, rather than by an occasional visit to a hospital as a consultant and advisor. In the past war the expert clinicians were scarce, because many of them were used on administrative problems.

The recent experience showed that the medical profession at large did not have any idea of just what was expected of medical men in the army. The result was that many physicians when they entered the service were considerably at sea as to what was expected of them and were especially disturbed when they found that there was work other than purely medical work to be done by the medical officers. Although in the future it is hoped that this non-medical work will be reduced to a minimum, it also would be well for physicians to familiarize themselves with what a medical officer must be able to do in the army, so that when they are called into active service they will realize what is expected of them.

As many medical men as possible should join the reserve corps and prepare themselves for work in the army if an emergency arises. In addition to that, however, the entire medical profession should be so organized that in case of war it can be conscripted, and some well informed authority see to the distribution of the doctors so that the army has its full needs and the civil population is not neglected.

In conclusion, let me urge that all medical organizations at the present time seriously consider the lessons that have been taught by this war. Let them, furthermore, organize in order to benefit by these lessons. Every state medical society should appoint a committee to investigate the whole subject and make recommendations. Committees from the various state societies should then meet in a national conference for the compiling of a report on the experiences in the recent war and the making of recommendations to the proper authorities in Washington.

***REFLEX SYMPTOMS OF THE UPPER ABDOMEN CAUSES BY CHRONIC APPENDICITIS.**

By Dr. R. W. WAKEFIELD, Bar Harbor.

It is the belief held by many, both within and without the medical profession, that in the unwarranted zeal of the modern surgeon to make a name for himself and pile up statistics, many normal vermiform appendices are sacrificed. This is probably true to a small extent. The whole profession of surgery is made to suffer for the carelessness and indiscretion of the few. My contention is that many diseased appendices are overlooked because all the symptoms are located in the upper abdomen, and these cases go on, year after year, treated as indigestion, gastric or duodenal ulcer or gallstones, until they fall into the hands of the Christian Scientists or osteopaths, or someone is wise enough to remove their appendix and cure them. Cases of this type are constantly coming under my observation, as they do most men in active hospital work.

HISTORICAL.

The literature on the subject is rather meagre.

Graham and Guthrie,¹ in their article on "The Dyspeptic Type of Chronic Appendicitis," say: "Cases of chronic appendicitis in which the stomach symptoms predominate have been a stumbling-block in the past to both clinician and surgeon, and to-day the symptomatology of the condition is far from being definitely settled."

In the early days many of these cases were operated upon by surgeons in general for ulcer of the stomach, and while no ulcer was found in the stomach a needless gastroenterostomy was performed for the so-called medical ulcer, which operation brought the patient trouble rather than relief.

It has long been noted that chronic dyspepsias have been cured in patients who for many years have been treated for chronic stomach disorders, in whom an acute appendicitis necessitated an operation. The attack at the time was thought to have been a separate trouble. Indeed, the profession has been slow in grasping the point that the stomach picture was due to chronic appendicitis.

Pain in chronic appendicitis is the great prevailing symptom, and is often manifested by a queer distress. This pain or distress is often epigastric, or so indefinitely abdominal that the patient describes it as

*Read before the County Meeting of the Maine Medical Association, June 19, 1919.

epigastric, when really it is abdominal. With attacks of dyspepsia with epigastric pain, with radiation to or about the umbilicus or lower abdomen, hold first and clearly to appendiceal disturbance.

In 1913, Aaron² called attention to the fact that in chronic appendicitis, though unsuspected, a continuous firm pressure with the ends of the first three fingers over McBurney's point frequently induced distress or pain in the epigastrium. While examining a case of chronic appendicitis with the X-ray, he was surprised to find that he was able to induce a pylorospasm by this pressure over the appendix. The pressure also produced a reflex pain in the epigastrium, of which the patient complained. He was inclined to believe that this pain was due to spasm of the pylorus.

He reports the following case:

Miss L., aged 23, American, with negative family history, had had mastoiditis on the left side two years before. She had stomach trouble for three or four years, with an acute attack sixteen months before, of epigastric pain and nausea, not associated with jaundice or vomiting. For the past eight months she had complained of a pressing sensation in the upper abdomen, occurring about thirty minutes after eating. The sensation was accompanied by erucations and was somewhat relieved by taking food. The physical examination showed a well-nourished young girl, presenting only epigastric pain on deep pressure over McBurney's point. With the X-ray it was seen that the bismuth and buttermilk introduced tended to remain in the upper pole of the stomach. The walls of the stomach were parallel; the pyloric portion well outlined; there were good contractions, and the duodenal cap was well formed and pointed upward. Pressure over the appendiceal region caused a spasm of the lower quadrant of the stomach and the first portion of the duodenum. The contraction was so pronounced that it prevented the passage of the bismuth meal through the spastic areas. In releasing the pressure, the pylorus and duodenum relaxed and the bismuth could be plainly seen passing through the pyloric canal and the first portion of the duodenum into the second and third portions of the latter. He thought this case gave an interesting demonstration of what we have long believed, that the gastric distress, eructation, and other symptoms of appendicitis are due to pylorospasm.

Black⁴, in discussing Cornell's paper on "Pseudo-Appendicitis," says: "In chronic gastric disorders there is probably greater confusion than in any other condition within the abdomen as applied to chronic appendicitis. In these cases the X-ray, the test meal, even

hemorrhage from the stomach, do not and should not convict any organ of ulcer."

"The absence of pain and tenderness does not absolve the appendix from possible guilt."

"Pyloric spasm is probably the chief factor of confusion between chronic stomach disorders and chronic appendicitis."

"Pyloric spasm is very common in chronic appendicitis, especially that form known as the obliterative appendix."

Writing from the Mayo clinic in 1910, Graham³ says that chronic recurring appendicitis is the type that usually gives stomach symptoms. "There is no appendiceal tenderness, no pain at McBurney's point, no fever, no tumor, no symptoms that usually mark appendicitis, except those referred to the stomach. There may be pain, gas, vomiting, sour stomach and pyrosis, but when compared to peptic ulcer they are irregular, and when gallstones are considered the attack is too prolonged."

The pain is often a queer, rather continuous distress, which is epigastric or indefinitely abdominal, which the patient describes as epigastric.

"Nausea, distress, a gassy, bloated condition covers the bad feelings of more cases of chronic appendicitis than of chronic ulcer or gallstones."

Pain may be epigastric only, but often indefinitely of the epigastric and abdominal regions, low gall-bladder or high appendix. If we have dyspeptic attacks with epigastric pain and radiation to the umbilicus or lower abdomen, consider, first, appendiceal disturbance.

Being very much interested in the subject under discussion, it was the author's pleasure to work out the sympathetic nerve connection of the solar plexus on the cadaver during the past winter. The phenomenon of spasm of the pylorus and first portion of the duodenum, induced by pressure in the appendicular region, causing epigastric pain, eructations, pyrosis, etc., is readily understood when one recalls the fact that the appendix has a rich nerve connection derived from the superior mesenteric plexus of the sympathetic, and from the cardiac, hepatic, and gastric plexuses. Therefore, any irritation originating in the appendix will easily send impulses to the other organs, and, as a matter of fact, often does. Because of this direct nerve connection between the appendix, pylorus and duodenum, chronic appendicitis may induce over this arc reflex gastrosplasm, pylorospasm and enterospasm.

Since we know that chronic appendicitis produces pylorospasm we can explain the etiology of the gastric symptoms of hyperchlorhydria so often associated with this disease, and at times the only symptom. The

damming back and retention of gastric secretion caused by pyloric spasm accounts for some, at least, of the ulcers so often associated with chronic appendicitis.

I report the following case as a good illustration of the subject under discussion:

Mrs. T., aged 33 years, housewife, married four years, no children. Family history negative. Personal history: Was always well and strong until seven years ago, when she contracted a heavy "cold," which developed into pulmonary tuberculosis and pleurisy. Was quite ill for several weeks, but finally, after one and one-half years' treatment, fully recovered. For the past two years, at first, following some indiscretion in diet, and later, even by careful dieting, patient would be taken with severe cramps in the epigastrium, nausea and vomiting. The pain would usually be confined to the epigastrium, but sometimes would radiate to the left abdomen, never going below the level of the umbilicus. There would be marked tenderness over the epigastrium and in the region of the splenic flexure of the colon. No distress or tenderness in the right abdomen during any of these attacks. At first, the attacks occurred about every three months, but recently every three weeks. I saw the patient in October, 1918, and she had been ill then for about one week. She had lost much weight and was very weak from lack of nourishment. There was constant epigastric pain, aggravated by taking anything into the stomach, constant nausea and frequent vomiting. There was great tenderness upon pressure over the epigastrium and spasm of the right rectus muscle. Supposing the patient was suffering from gastric or duodenal ulcer I made the usual tests, but found nothing positive except an excess of hydrochloric acid. In the meantime the patient became desperately ill and immediate operation was decided upon. Operation Nov. 8th, 1918. Right rectus incision. Stomach, pylorus, duodenum and gall-bladder found perfectly normal. Retrocecal appendix found buried in adhesions about the cecum and removed with some difficulty. The organ was inflamed and undergoing obliterative changes. Stormy convalescence for one week following the operation, and I believe the patient's life was saved by frequent gastric lavage. After this convalescence was satisfactory. Patient now has gained twenty pounds in weight, feels perfectly well, and has had no further trouble.

CONCLUSIONS.

1. Chronic appendicitis may, and often does, cause reflex symptoms in the epigastrium while there is entire absence of symptoms in the region of the appendix.

2. These reflex symptoms are produced through the sympathetic nerve connection of the solar plexus.

3. Pylorospasm accounts for the hyperacidity and delay in emptying the stomach so often seen in these cases.

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THE PRESIDENT: The paper is open for discussion.

DR. JACKSON, of Houlton: Mr. President, several things in connection with Dr. Wakefield's paper would seem to be pretty important. He spoke of the fact that chronic appendicitis may, and often does, follow reflex symptoms in the upper right abdominal quadrant, and that a great many patients have had their appendices removed without the good results that the surgeon thought at the time would ensue from the operation. I think this is true oftentimes. Certain types of streptococci have a selective predilection for the appendix and gall bladder, and in many of these cases we not only have a chronic appendicitis, but we also have a type of gall bladder which has been described by Charles Mayo as the strawberry gall bladder. A strawberry gall bladder, in my opinion, simply holds the same position in the right upper abdominal quadrant as the chronic appendicitis does in the lower. It is a diseased gall bladder, and undoubtedly is caused by the same group of bacteria that are found in appendicitis, and I think that one of the first things to be done in the abdominal opening is to carefully explore the right upper abdominal quadrant. In this connection, I had a case some two or three years ago in which the man presented symptoms of trouble in both regions. The condition was so apparently grave in the lower right part of his abdomen that I opened that and took out a gangrenous appendix. To my chagrin he presented a very definite mass in the region of the epigastrium. I opened that and did a posterior gastroenterostomy, but to my surprise he promptly recovered. That was over two years ago and the man to-day presents absolutely nothing in the region of his pylorus, and so far as I know he is well.

THE PRESIDENT: This is a subject that never will grow old. It must be that every physician in this room has had experience in this class of cases, and it does seem that they should give us the benefit of their experience.

DR. STURGIS: Mr. President, I am glad to hear the paper because it brings back to me this thought that there is good evidence of the chronic appendicitis

in the epigastrium and even higher. I saw a case in consultation a few days ago where there was evidence of the chronic appendicitis, the chief symptoms of which were evidence of trouble with the lung. The patient complained of respiratory trouble. This shows how high the reflex conditions may go, as Dr. Wakefield suggested. That patient complained more of respiratory symptoms than of the appendix. Nothing could be found by auscultation or any of the usual methods. It was finally decided to operate and we found chronic appendicitis. On the other hand, we know how many times the condition of the lung simulates appendicitis and gives us the misfortune to operate for appendicitis just before the breaking out of definite pneumonia. Many times it has been called ether pneumonia when I believe it was nothing of the sort. It was in existence previous to the use of any ether.

I had an experience at the time of the influenza epidemic that was rather trying. I was called into the country to see a man who was going through active flu with pneumonia. I found free blood in the sputum. He was diagnosed as having an acute appendicitis. I responded to the call and I found the man in such shape that we did not dare to give him any anesthetic. I operated on him without any anesthetic, one man holding his hands and another his knees. I found the appendix ruptured, free pus in the abdomen,—I thought a pretty grave condition. That man came out all right, and after he got well he told me that he had been troubled with an old stomach trouble for years. In other words, I believe that man had a chronic appendicitis which never would probably have broken out into an acute condition had he not had the flu pneumonia. It just shows, and the paper brought to my mind how many times in these cases the symptoms are far remote from the surgical region of the appendix, even to the lung or the epigastrium. I thank you.

DR. JACKSON: I would like to know the nature of that pulmonary trouble. Were there asthmatic symptoms?

DR. STURGIS: There were.

THE PRESIDENT: If there is no further discussion, will Dr. Wakefield have anything more to say?

DR. WAKEFIELD: I have nothing more to say, Mr. President.

***PSYCHOPATHIC PERSONS.**

By DR. F. C. TYSON, Augusta.

The use of the term "psychopathic" is becoming quite general in its application to all sorts and conditions of mental abnormalities, even though the specific conditions to which it is applied are not always clearly understood. Psychopathic pertains to psychopathology, a diseased condition of the mind, and is rather more extensive in its application to mental disorders than "insanity," because the latter expression is not usually applied to what may be ordinarily considered as constitutional defect or idiocy. Psychopathy, or mental disease, has a medical and scientific significance, while insanity implies legal and social considerations. This differentiation makes clear the objection to the use of the term "insanity" as now applied to cases of certifiable mental disease. The stigmata of legal taint in the formal establishment of the fact of insanity in an individual, with its attendant loss of certain constitutional rights and social standing, lingers longer in the mind of the patient, relatives and friends than the fact of the mental disease itself.

To develop a mental disorder is certainly a misfortune and often a serious calamity, but to be declared insane is an humiliating procedure and frequently considered a disgrace, so let us encourage the use of the term "psychopathic" as pertaining to abnormal mental conditions if for no other reason than that it helps to sustain the self-respect of the patient with the knowledge that his difficulty is a medical as well as a social problem.

Those of us who have to do with mental disorders, either as disease entities or as social problems, recognize the fact that many individuals present certain personal peculiarities and anomalies of character that are usual or normal to them, but which do not always constitute a psychosis, yet often lead to an inefficient type of adjustment. Such individuals may, however, show an actual psychosis at times, but more often are considered simple border-line cases that can be cared for outside of a hospital by relatives with the aid of some social agency. These individuals are not considered to be insane in the ordinary sense, because their conduct may be free from any serious disorder, even though the psychopathological features may be more complicated and unclear than in the case of a person suffering from the maniacal phase of Manic depressive insanity. The psychopathic individual may be

* Read before the Maine Conference of Social Welfare, Portland, Sept. 25, 1919.

able to control and regulate his conduct to a degree quite incompatible with his feelings and impulses, while the opposite is true of an ordinary case of excitement.

The management of the border-line case in the psychopath that is not severe enough to cause much disturbance in conduct is a difficult problem and often taxes the ingenuity and resourcefulness of the social worker to the utmost. If the psychopath presents an actual psychosis he may be cared for in a state hospital, but if no definite mental disorder can be shown such a procedure is not always justifiable, unless commitment is necessary in order to insure proper treatment. The establishment of psychopathic clinics under the direction of physicians experienced in the nature and treatment of psycho-pathological conditions in the larger cities, and psychopathic wards in connection with general hospitals, has had a tendency to relieve this difficult situation and afford the patient much benefit. It is, however, difficult even at the present time to induce these individuals to come to such a clinic because of the fear that their condition will be considered a form of insanity. The specially trained psychiatric social worker has done much to overcome this difficulty.

The psychopathic individual is subject more than anyone else to any or all of the various forms of mental disease, although all persons who develop a mental disorder are by no means psychopathic. The individual, for instance, who after syphilitic infection begins to show symptoms of nervous syphilis or general paralysis, may have been normal in make-up. A study of the life histories of many such unfortunate persons has failed to reveal any previous peculiar traits in character or personality that would have aroused any suspicion of impending or even ultimate mental disease. On the other hand, all indications pointed clearly to the promise of a normal and useful life. Such a case of mental disease is the direct result of an exogenous factor accidentally introduced into the body from the outside which might easily have been prevented.

It is easy to understand why insanity develops after an injury to the head in which the brain is affected, but it is not so easy to understand how a mental disorder develops out of the personality of a constitutionally psychopathic individual.

General paralysis begins as an organic disease of the brain caused by syphilis. It is characterized by a definite pathology, clinical course and outcome. The course is rapidly progressive and death results usually in from two to five years after the onset of the disease. While important organic diseases of the brain, such as general senile changes, general paralysis may be considered the best example, there are other

organic degenerations due to disease of the arteries, brain tumors and injuries. In all these conditions, physical causes have produced serious mental disorders from which recovery cannot be expected, except possibly in a few cases due to injury.

Another group of mental disorders is dependent upon special causative factors such as bacterial infections, states of exhaustion, intoxications and poisons, all of which are fairly simple mental disorders which do not cause permanent mental impairment and recovery follows.

We do not, however, consider the functional mental disorders in terms of pathology brought about by definite and clear-cut external influences. Disease of the brain is not always necessary to explain disordered function. Mental and moral features may figure prominently in the etiology and the resulting mental disorder will represent an abnormal reaction to the ordinary events that enter into the lives of everyone. This is made clear by Meyer in his psycho-biological concept of the functional mental and nervous disorders, who states that the types showing mental defect and deterioration present substitutive reactions, that fundamental discrepancies exist between thought and action and the disorder represents mental conflicts, with ideas that are a source of disharmony which the individual is unable to handle in a healthy and adequate manner. A study of the functional disorders gives one a better insight into the type of personality that succumbs to these conditions than the detailed study of psychopathic conditions without reference to any actual psychosis.

The most serious, and therefore the most important, functional mental disorder is dementia præcox. It is a mental disorder with more clinical variations than the others, and the fundamental symptoms being more serious and progressive, most cases end ultimately in severe mental deterioration. The disorder begins in early life, soon after adolescence and forms a large group which constitutes the bulk of the chronic insane in institutions as a result of the unfavorable outcome.

The designation dementia præcox, which includes all of the various adolescent mental disorders, requires an explanation. The word dementia is applied to those conditions that have a marked tendency to permanent mental impairment. It indicates an acquired permanent mental defect and not a mental disease. The word præcox implies that the disease occurs early in life. This explanation might wrongly be construed to imply a close analogy with senile dementia, a mental disorder occurring late in life and due directly to loss of vitality of the brain incident to old age. An inference of this nature would imply that the brain succumbs to the same sort of influence early in life in-

stead of at that period of life when it is to be expected. The mental mechanisms of dementia præcox, however, are entirely different and bear no analogy to senile dementia.

The type of psychopathic person who develops dementia præcox has been the subject of much recent investigation as a result of a change in the general conception as to the nature of the disease. The dementia præcox case appears to be absorbed in unhealthy trends of thought which result in disorganization and deterioration of mental and physical habits. There is a loss of interest in concrete things and an unhappy adjustment to the environment results because of improper habits of thought. When dementia præcox was considered generally as a circumscribed process caused by some toxic agent the constitutional make-up of the individual was not considered of special importance in its development. It is a common observation that peculiar traits of personality seem to be more frequent in cases which develop the more severe disorders. This is specially true of the dementia præcox personality which has been aptly described as "shut in." In such a person, normal mental life is difficult because the mental processes are hampered and warped by unhealthy ruminations, and faulty adjustments take place because of the narrow introspect, shut-in personality.

Manic depressive insanity presents a decided contrast to dementia præcox. It is a disease of characteristic form and simple fundamental symptoms in which the mechanisms of development are harmless in nature and terminate ultimately in recovery. This disorder is characterized by either periodical attacks of maniacal excitement, in which the mental and physical activities are greatly accelerated and accompanied by emotional elation, or by depression in which the same activities show retardation with emotional depression. In this disorder, as well, we see perhaps more clearly the relationship between the mental characteristics of the psychopathic individual and the principal features of the subsequent mental disease. The mild forms of Manic depressive insanity seem to be a continuation of further development of a peculiar personality, but in the more marked states of the disease the personal peculiarities are completely submerged and the relationship cannot be recognized. The same condition obtains in the organic disorders as a result of a defect produced by disease processes.

The psychopathic types that are predisposed to Manic depressive insanity are those that are inclined to extremes of emotional reaction. Those that develop the Manic phase are often over-active, stirring, inclined to overdo, vivacious, intense and easily excited. Such in-

dividuals are often high-strung, very enthusiastic and have a violent temper. Those that develop the depressed phase are subject to "blue spells," are morbid and inclined to fight their battles over again. They borrow trouble, worry over trifles and show an instability of mood. Exaggerated emotional traits seem to be the most characteristic feature in a large proportion of persons who develop Manic depressive insanity.

As we become more familiar with the psychopathic personality and the predominating features become more circumscribed, we are able to split off more or less definite disorders that can be considered as distinct clinical groups. We may separate the essentially organic conditions which are dependent upon organic changes due to clear-cut external influences, in which the peculiar traits of character are not of much importance, from those conditions in which the disorder is essentially psychological in its development, and very often the outgrowth of an unstable, often inherited psychopathic constitution. A study of the personality enables us to separate the purely mental from the purely physical causes. The hysterical individual suffers from buried complexes of the past; the psychasthenic gets into difficulty by morbidly anticipating what the future will bring. The neurasthenic cannot adapt himself to the requirements of the present, while the constitutional defective is handicapped by lack of the essentials of normal mentality, and his reaction is practically a biological deviation.

In the absence of time sufficient to prepare cases illustrating the various types of psychopathic personality I must confine myself to generalities and point out certain fundamental principles. The most minute and painstaking analysis of the personality would still leave you in doubt as to the mechanisms from a psychological standpoint, a working knowledge of which is quite necessary, not only for the psychiatrist, but for the social worker.

We learn from psychology that we are all sensitive when certain subjects are mentioned, which means that when certain trends or conflicts of ideas are brought to our attention intense emotion is produced. Such groups of ideas are known as complexes that are usually recollections of painful experiences that have modified more or less the normal or abnormal working of the mind. These mental experiences may include many topics in general, as feelings of shortcoming, sensitiveness over personal defects or lack of ability in different directions, all of which are associated with feelings of wounded pride, guilt, remorse or shame. Consciousness of certain longings and desires that cannot be fulfilled or gratified are a source of mental disharmony. Such trends are of vital importance in the personality of an individual and often involve questions of right and wrong or interfere with cer-

tain fundamental instincts of the personality, as, for instance, the sexual life in its broadest sense. These trends or groups or ideas are represented as mental undercurrents that do not appear on the surface because they have been repressed as incompatible with the life and happiness of the individual. Such repressions may be so complete that the individual may not be clearly conscious of them, which makes it all the more difficult for him to maintain his sanity.

These undercurrents are constantly modified in one direction or another by the every-day experiences of life, such as the attracting and repelling influences of mutual intercourse. They are influenced by the treatment received from others, the attitude they bear toward us, by successes and failures, and, in fact, by all those factors which we meet in every-day life. A well-balanced mind meets and disposes of these factors in a healthy manner by meeting them with good judgment and a proper appreciation of correct values. Some possess a healthy fighting spirit, which enables them to shape conditions around them. Others find relief in unburdening their thoughts in a healthy manner. Some avoid trouble by taking up outside interests or cultivating hobbies, all of which are beneficial and tend to widen one's horizon and broaden one's view of life so that the painful memories lose some of their feeling tone. These are a few of the normal reactions to the undercurrents that are a source of mental disharmony. As people vary in defense, their conflicts vary in intensity, and poorly balanced or psychopathic persons, instead of handling the situation in a normal manner, break down and react abnormally by developing a mental disease.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

EYESIGHT TESTING BY MOVING OBJECTS.

Whoever took the trouble to read the annual address of the President of this Association delivered in June, 1918, may have noticed in it the entirely novel idea that the ordinary eyesight testing of soldiers and sailors was defective from the standpoint of military or naval marksmanship, if based on the perception of immovable test types alone. The address above mentioned suggested, for the first time in the history of ophthalmology, so far as can be discovered by available literature, that, as all opponents on land or at sea were in a vast proportion of instances "on the move," vision to enable soldiers or sailors to hit their mark, depended almost exclusively upon their ability to distinguish the moving forms of men, horses, artillery and ships, and should be tested in that direction in the case of all recruits. This suggestion has so far failed of recognition, chiefly because it was offered to an audience composed almost exclusively of general practitioners of medicine, and was ultimately printed in a medical journal devoted simply to general medicine.

If not, now, the first suggestion in this direction, it is an early one, and although not so far utilized by recruiting officers, yet two papers bearing upon the same idea from different points of view bring additional support for its usefulness. Riddoch, for instance, read before the Philadelphia Neurological Society in January, 1919, a paper in

which he argued that the recognition of the movement of objects is part of a special visual perception, and that in various instances of recovery from blindness, the first symptom is a perception of the movement of test objects in the periphery of the field of vision. Appreciation of such movements, and the visual recognition of the object itself, are separate items in the recovery of vision, the perception of the movement anywhere in the field of vision being the more primitive of the two, because the region for such perception is so much more extensive than that for the sensory recognition of the object itself by central vision at the yellow spot. From a prognostic point of view, moreover, this observation has its value, for if a blind patient begins to notice the movement of objects in the outer field of vision, he stands a chance of regaining later some central vision also.

In the next place, Spiller (*A. M. Journal of Medicine and Science*, April, 1919), mentions an acromegalic patient, and asserts that the recognition of the movement of objects in the nasal half of the field of vision after central vision had been lost for recognition of the object itself proved the presence of a pituitary tumor when other symptoms were inconclusive.

From these papers, therefore, it would seem that a careful study of the difference between the central perception of ordinary fixed test type and the perception of movement of similar types, or objects of different shapes and colors, as well by central as by usual field perception, would be well worth cultivating. We suggest, therefore, that in the future recruits shall not be asked solely to name the letters, but that they shall prove what size of objects they can discern moving about in their fields of vision, near the center, as well as in the periphery.

Finally, let us not forget how essential the perception of movements is to beasts of prey for self-preservation as well as for obtaining food supplies. So, too, this perception saves us from motor accidents, and if studied, mapped out, and increased by exercises, would make better recruits for both services and additionally preserve them more safely from enemies moving more or less to the side of either eye, but surely perceived as moving, by the retinal elements in the visual fields.

WASTED WAR EXPERIENCES.

We notice with extreme pleasure that at almost every one of our late county medical meetings reports on their war experiences and war work in camps, at home and overseas, are being listened to with keen interest from fellow members of our medical service. We regret

exceedingly, however, to say that in almost every instance such reports, histories and experiences fail in their full value simply because they are spoken offhand or from the slightest hint in the way of notes, and not in a single instance from typewritten or written manuscript fit for preservation.

"Preserved history" is what the Maine Medical Association and Maine medical history wants. We therefore urge every war physician to write out in shape his adventures, memories and reminiscences of every possible personal nature before they have left his memory for good and mostly for all time, for not only will all such papers be invaluable for medical history of Maine and of the nation, but for the wife and children of all so blessed. We hope most urgently, and we desire almost inexpressibly, that every medical man from Maine will take the time, or make the time, to write out in full all that he did from his uprising until his resting out at night, and just what he did for Maine and for the Nation and for his own people.

What would we not give for the experiences of men of the past who have gone along and left no traces of their deeds. What will not your wife and your children have of deep regret when they look upon you, dead, and think that you did nothing to keep them informed of the way in which you did your duty to the state in which you practiced, to the Nation to whom you swore allegiance, and to the world to whose rescue from arrogant militarism you did your share. Here, then, is a beacon light for you war surgeons from Maine to hang up in your paths, daily, until you have reached the safe harbor of some sort of a written or typewritten or printed story of what you did in the greatest war that has ever envisaged this round world of ours.

DANGERS WITH ELECTRICAL BATHS.

All England has been lately excited by the instantaneous death, in his bath tub, of a man who suffered from rheumatism, and who was in the act of applying an electrical vibrator to the upper part of his body when the accident occurred. The vibrator was attached to an ordinary lighting socket and there was no rheostat or current interrupter. At the inquest it was shown that one of the wires connecting with the vibrator had corroded, with the result that the machine became "alive" when the current passed through the body of the man surrounded with water. Other cases have been reported in Great Britain of late, in which death has occurred from flaws in the electric fittings, the victim attempting to switch off or on an electric light whilst most of his body was immersed in water in a

bath tub. In another recent instance death occurred whilst socketting a defective lamp, the victim happening during the act to be standing on a wet iron grating in a machine shop.

The lessons to be learned from such accidents are, that no one should ever attempt to unscrew or replace a defective or apparently burnt-out lamp without switching off the current, and that no electric vibratory apparatus should ever be utilized in the homes of patients without the supervision of an expert. All electrical apparatus for lighting in every bath room should be most carefully insulated, and so placed that nobody standing or sitting in the bath tub, with the water in it, can possibly touch the buttons to turn off or on the street current.

If accidents occur, first switch off the current, then be careful not to touch the victim in the water with bare hands. If rubber gloves are accessible, use them, if not, then wrap the hands in several folds of dry towelling before attempting to touch the dead person. Artificial respiration may be tried when the dead person has been taken from the water, but it has rarely if ever been successful.

Most of us have become so used to electricity that we consider it perfectly safe, whilst on the contrary, under such circumstances as defective wires, wet shoes and stockings, standing on iron mats or mats of meshed wire or even wet floors, and especially in changing bulbs, serious and even fatal accidents are constantly occurring.

SENSIBILITY OF THE EYES TO PRESSURE IN LOCOMOTOR ATAXIA.

When a healthy eye is pressed down into the orbit, it exhibits at a certain stage of pressure a special sensibility of its own, a deep-seated acute pain similar to that produced by pressure upon the breasts, trachea, testicles, ovaries and epigastrium. This sensibility, however, is diminished in various diseases of the tunics of the eye itself, but so far no especial study has been made to differentiate this sensibility in eye diseases strictly speaking. Nor do we find much advance concerning the variations in sensibility occurring when the eye itself is apparently free from disease, but the patient suffering from various constitutional affections. Sometimes with such affections we find sporadic instances mentioned in medical papers of hyperalgesia, and again of analgesia of the eyes, even to a total absence of all sensibility except when pressure is most extremely applied.

Recent studies of this state of affairs in locomotor ataxia shows

many points of considerable value as a means of diagnosis, but so far a precise determination of what this condition or that means as a symptom of the constitutional disease has not been obtained. But just as in tabes we have visceral neuritides of various types, so the ciliary nerves of the eyes give off various symptoms as to hyperalgesia or analgesia most deserving of careful study by clinicians and ophthalmic surgeons. It has long been known that the pupils vary in locomotor ataxia, showing in one case certain symptoms, in others certain variations from the former type, and just as these have been studied by mutual co-operation between the physician and the specialist, so, too, the condition of the sensibility of the eyes to pressure deserves proper mention and combined study by these two sets of practitioners. If to the ordinary symptoms of this serious disease we can add eye symptoms suggesting its initial appearance in the body, we shall be gaining a chance to prevent, in some human probability, its steady progress in spite of many remedies so far discovered and widely utilized.

A NEW NURSING PROBLEM.

A late number of *Southwestern Medicine* has a good paper on the need of more nurses than can at present be obtained in that part of the country. Our own Maine General Hospital also, at its annual meeting lately, complained of fewer applicants for nursing than ever before. Whether this lack of trained nurses is true for all parts of the nation, we do not know. On the ground, however, that nurses are needed always, it is for us to say something on this important topic concerning public health. In so doing we utilize some hints from the paper above mentioned, which argues that since the great war ended there has been a lack of applicants for instruction in nursing, and a lack of training bases. The chief trouble seems to be in the higher requirements and the longer course of training now insisted upon. California, for instance, at the demands of the State Department of Health, compels a woman who wants to be a nurse to come forward with four years of a high school education, together with an equivalent year in chemistry, household economics, physics, biology and one foreign language. After passing a rigid examination on such a foundation of study, the nurse must promise to spend four entire years in a hospital before she can appear for final examination for registration.

To a distant observer it would seem that any young woman who had mastered all of these requirements for a mere entrance examina-

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tion to become a nurse would do a great deal better for herself to go ahead and study medicine and practice that for a living, rather than limit her broad scope of education to being merely a nurse, no matter how thoroughly trained.

The writer of the paper mentioned objects to such extreme demands and requirements, and says that she found from the French surgeons overseas that the care and the recovery of operated and sick or wounded soldiers was as satisfactory when they were looked after by French women of three months’ training as they were under the exclusive care of three years’ trained nurses.

The whole thing lies right here, is trained nursing to be a humane vocation or an educated business? Is it not plain that the higher the requirements and the longer the training demanded for nurses, the higher is going to be the cost to the patients. What with higher nurses’ wages and higher medical fees, the end plainly in sight from these two heavy demands upon the incomes of the sick and the operated and the injured is just one thing, state wages for the trained nurses and the trained physicians alike.

We ask, now, if there is not some hospital in Maine in which in one single year any smart young woman can learn how to take care of the ordinary sick patient with skill and humanity combined, leaving to the three years' trained nurses or the four years' trained nurses the more exacting and scientific care of the surgically operated and accident cases, and the training for official positions such as superintendents of nurses, and also of hospitals?

We know of many simple country women of to-day who go about in their little villages doing good work for the sick at moderate prices. All that they need sometimes, in some difficult cases, is a little more experience and a little more book education. Even as they are, they are excellent servants of reality, amidst the ups and downs of health and illness in a scattered population like that of Maine. From the ranks of such women, the demand for visiting and district nurses could well be filled in the present scarcity of higher and longer trained nurses from the hospitals, brought about by too high requirements and too prolonged an education for the position which they have to occupy.

COUNTY SOCIETY IMPROVEMENT.

We take the following from the *Michigan Medical Journal* and commend it favorably to every county medical society as a good and novel move. This is, that during the month of September last the following plan was carried out by the Attawa County Society in Michigan. On certain days the officers of the society, accompanied by several members, went off on a motor tour with the intention of calling in on every doctor in the county. The idea was to stimulate the regular members to renewed interest and activity in their society. Likewise, when occasion served, they called in on men who did not belong and offered reasons why they should take his important step. In brief, their intention was to stir up professional interest and activity in their county society, to become better acquainted with one another, and to plan, incidentally, for a winter of profitable meetings.

This is a movement that may well be followed by other societies, although it may be too late to begin with winter at hand.

This also brings to us of the editorial chairs the request that if any member has any idea, thought, or suggestion for this JOURNAL, or for the county society, or for individual members, let him send it along. We want to stimulate communication between our members for the good of the profession as a whole. The JOURNAL is the only medium at your disposal for doing this, and we hope, pray, and beg, that in-

stead of doing all the work, cheerfully and to the best of our ability, yet we will not only not refuse every kind of help, but we will gladly welcome it from every source.

A WESTBROOK BOARD OF HEALTH PAMPHLET.

The State Department of Health has sent us a copy of their pamphlet concerning health conditions in Westbrook. In addition to detailing faults to be found, the board offers plain advice regarding many points of public health. We are extremely glad to notice, amongst other suggestions, that there is absolutely no medical inspection of the public schools and that it should be seen to at once. We agree with this in every respect, and can only reiterate our repeated advice, that every community in Maine owes to its children an examination that shall give them evidence, on a permanent card, that they are in reasonably good physical condition. Maine, as we have over and over again said, lost forty-five soldiers out of every hundred called to the ranks. Let this never happen again in another war, which is sure to come, sooner or later, leagues or no leagues, because a quarrelsome nation will always be swaggering through the world asking to be put into decent order and respect for the rest of the people of the world.

TO ALLOW PHYSICIANS TO PRACTICE IN ALL STATES.

A federal bill for this purpose has been introduced into the House of Representatives. Any physician who has studied four years in a medical school, and has been granted a state license or any person admitted to practice and has practiced for five years, may have license to practice throughout the nation. For this permit, ten dollars will be demanded, the license to be recorded with the Department of Health in the state in which the physician practices. The number of the bill is H. R. 8313. It is not stated whether the fee shall be paid for every removal from one state to another.

Correspondence.

PORTLAND, MAINE.

Dear Doctor:—Recently I have had brought to my attention several complaints and requests for information against and concerning physicians who are supposedly practicing illegally in this state. All of these complaints have been made by letter to Dr. Spalding, our recent President of the Maine Medical Association, who, in turn, handed them to me. They have all been investigated and the information wished has been given.

Might I say, through you and the columns of the JOURNAL perhaps, that one must remember that in 1895, when the present Maine State Board of Registration was instituted, "physicians" who were non-graduates, but who had been in "practice" previous to that date, were registered as physicians and surgeons as prescribed by law. Hence we have at this time a few such practitioners, and it has been concerning these men that most of the requests for information as to licensure and right to practice came.

We have, too, in this state, at the present time, some itinerant advertising physicians and "specialists." These men are all registered physicians of the state, hence I would say in response to the several complaints made against them, that, unfortunate as it may be, they have the legal right to practice.

Revocation of licenses is possible only in those cases where conviction for crime or felony is obtained. We, as a Board, have no power to revoke the license of any practitioner in any other way.

Egotistical as it may sound, I would state that if any medical man would make complaint direct to the Board of Registration or to me, I shall be pleased to see to it that action is taken when possible and needed.

Yours very truly,

ADAM P. LEIGHTON, JR., M. D.,

Chairman of State Board of Registration of Medicine.

November 5, 1919.

To all Citizens Interested in Fighting Tuberculosis :

Will you be as surprised as we have been to learn that over 25,000 residents of Maine have died of tuberculosis within the last twenty-five years? That in our generation twenty-four thousand three hundred and sixty-five of our neighbors and our neighbor's

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children have been claimed by tuberculosis of the lungs alone? That approximately half of these (11,257) died in the very flower of manhood and womanhood, between the ages of twenty and forty, and that most of them might have been saved?

The state-wide campaign committee is endeavoring to raise an amount of money during the first ten days in December large enough to carry the fight against tuberculosis into every county of the state next year. If this is done, further solicitation of funds will not be made for the year's work.

If you have not already given according to your interest and ability, please mail check or money order, made payable to the Maine Anti-Tuberculosis Association, to the treasurer, 27 State Street, Bangor.

Yours very sincerely,

CARL E. MILLIKEN,

Chairman.

RALPH WHITTIER,

Treasurer Christmas Seal Campaign Committee.

F I G H T

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County News and Notes.

PENOBSCOT.

PENOBSCOT COUNTY MEDICAL ASSOCIATION.

The annual meeting of the Penobscot County Medical Society was held in the Bangor House, November 18, President E. E. Brown, M. D., presiding. There were thirty-seven members present.

The following officers were then elected:

President, Dr. W. E. Fellows.

Vice-President, Dr. J. B. Woods.

Secretary and Treasurer, Dr. Harry D. McNeil.

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These are considered the best-cooked cereal foods in existence and best fitted to digest.

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Puffed Wheat
Puffed Rice
Corn Puffs

Member Board of Censors, Dr. C. M. Thomas.

Member House of Delegates, D. H. H. Crane; alternate, Dr. H. L. Robinson.

County Editor, Dr. H. D. McNeil.

A rising vote of thanks was tendered the retiring board of officers.

Dr. Edward R. Mansfield, of Millinocket, and Dr. Robert R. Jangigian and Dr. R. W. Fellows, of Bangor, were elected to membership.

Dr. Carl J. Hedin, Superintendent of the State Hospital, admitted to membership by transfer from Cumberland County.

Adjournment was then made to the dining hall, where the retiring president, Dr. E. E. Brown, delivered an extremely interesting paper, entitled, "Observations of Changes in the Field of Medicine."

H. D. McNEIL, M. D., *Secretary*.

NEW AND NON-OFFICIAL REMEDIES.

Non-proprietary Articles :

Neocinchophen.

Calco Chemical Company :

Neocinchophen—Calco.

Hollister-Wilson Laboratory :

Pituitary Solution—Hollister-Wilson.

Ampules Pituitary Solution—Hollister-Wilson.

Pure Gluten Food Co.:

Hoyt's Gluten Special Flour.

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Its treatment with

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See "*Southern Medical Journal*," July, 1919, page 370

"Case 4.—Mrs. G., 30 years old. She has been suffering for several years with very acute attacks of asthma, which were not relieved by adrenalin and required morphin injections several times. The patient was given 20 drops of 20 per cent. solution of benzyl benzoate four times a day and was improved more than by any other treatment. The blood examination showed 15 per cent. of eosinophiles."

DYSMENORRHEA AND OTHER COLICS

See "*The Journal*" A. M. A., August 23, 1919, pages 599 and 601

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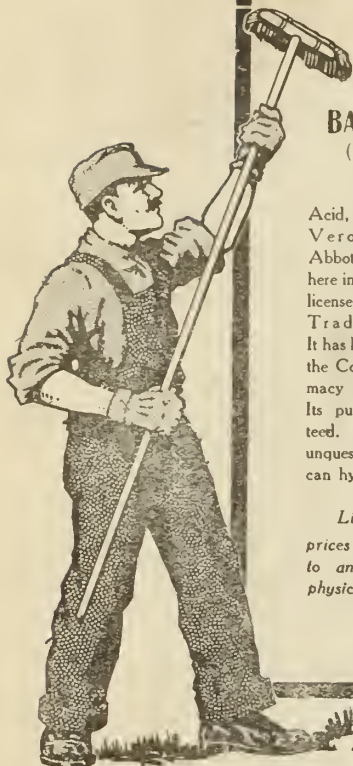
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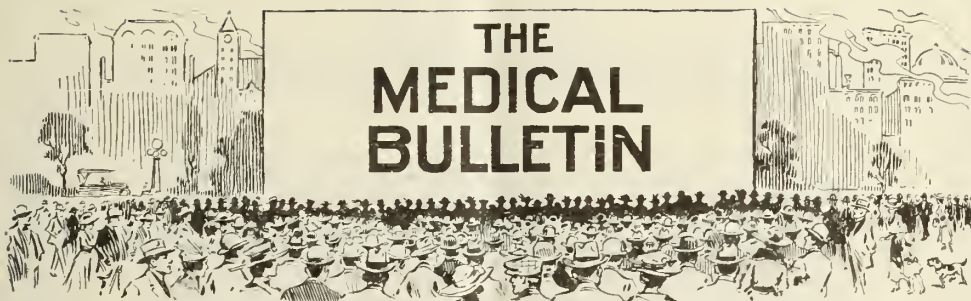
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***TREATMENT OF PNEUMONIA BASED UPON RECENT CLINICAL, BACTERIOLOGICAL AND PATHOLOGICAL FINDINGS.**

By L. L. POWELL, M. D., Portland, Me.

The pathologist and the roentgenologist have held "front stage" during the past two years in the theater of medical and surgical activities incident to army practice, both at home and abroad. Never before were such opportunities accorded observers in these lines for unlimited study and original work on the respiratory diseases. The government has stood for every expense, and the unprecedented epidemics in our big camps and base hospitals have furnished ample material. The internist, also, with these great aids at his command, has been in a position to check up his work in diagnosis and make immediate use of the newest discoveries to an extent impossible under other conditions, and as a result we find a vast amount of study and experimentation to have been carried on.

To the busy physician in civil practice who has not been able to follow closely the recent literature, and to the army surgeon, also too busy on the front lines to keep in touch with all the newer findings and reports, a perusal of the medical journals for help and inspiration in the management of the respiratory diseases proves little short of bewildering. The magazines are replete with reports, and the reports are besprinkled with charts and tables to a point where one finds himself in a maze of more or less scientifically arranged data that seldom

* Read at the annual meeting of the Maine Medical Association, June 19, 1919.

gets one anywhere outside of a sort of vicious circle. Every phase of these diseases has been noted and reported upon. Every possible method of treatment, whether practical or otherwise, so long as a theory could be attached to it, has been tried out and catalogued.

To select from this data something definite and tangible that can offer positive advance in the treatment of the pneumonias, and to so present it in concrete form as to give a working basis for the treatment of each type of pneumonia once the diagnosis is made, has been the objective sought in the research behind this paper, and that, too, in the interest rather of the general practitioner with limited means for special bacteriological and pathological work than of the internist with an institutional laboratory at his command.

The ravages of pneumonia during the past year have intensified the feeling that no stone should be left unturned toward clearing the way for a positive, efficient management of this disease. Under ordinary conditions pneumonia ranks next to tuberculosis as a cause of death, and during the past year and a half it has been the prevailing terminal disease, both at home and abroad. With a mortality rate ranging as high as 65%, it has been the despair of clinicians everywhere, regardless of their position in the medical profession or their facilities for handling the disease.

The term "pneumonia" can no longer be applied in fact to a disease entity, since so varied is its character, both as regards causation and symptoms, that it is already generally regarded not as a single disease but as many diseases under a single name. Recent writers not only look upon lobar pneumonia as a disease due to one of several types of organism, but on broncho pneumonia also as of several different and distinct varieties and demanding special treatment.

LOBAR PNEUMONIA.

Lobar pneumonia has for several years been the subject of a great deal of study and experimentation with a view to progress in method of treatment. Most of this study has been directed toward some form of specific treatment with vaccines or serums. Up to the beginning of 1918 great progress had been made, and already the treatment of lobar pneumonia had been placed (with certain limitations) on a scientific basis—not ideal by any means, but far in advance of previous effort. A summary of work accomplished and conclusions drawn up to this period would note the following facts:

1. Lobar pneumonia, with pulmonary lesions clinically indistinguishable, may be caused by the following organisms in about the proportion given:—*streptococcus pyogenes*, 9 cases; *staphylococcus*

aureus, 3 cases; bacillus influenzae, 6 cases; Friedlaender bacillus, 3 cases; diplococcus pneumoniae, 454 cases out of 529 cases examined; 49 cases undetermined. (Avery et al., Monograph, Acute Lobar Pneumonia, 1917.)

2. The diplococcus pneumoniae itself is of four distinct types. Lobar pneumonia resulting from Type I organism readily responds to treatment with a specific serum for this type which is administered intravenously. More than one-third of the pneumonias occurring in ordinary periods is caused by Type I organism. (32) Pneumonia caused by Type II, Type III and Type IV are not so responsive to specific serum treatment.

3. The type of organism in each case of lobar pneumonia is readily determinable by culturing the peritoneal exudate of a mouse a few hours after it has been injected with a small portion of the patient's sputa and then testing the growth by the agglutination method with a specific serum of each type. This is simple but requires the technique of a skilled pathologist. A second method, and much simpler for the general practitioner to perform, is the so-called precipitin reaction in urine. This is based upon the fact that the urine of a lobar pneumonia patient may contain a soluble substance of pneumococcic origin which causes a precipitate when brought in contact with a specific serum of the type to which it corresponds. This is not as conclusive as the former method, but is simple, time saving and decidedly helpful. Out of 80 cases tested out at the Rockefeller Hospital, 52 urines gave a positive reaction and the cases not giving reaction to some type were too mild in character to prove fatal. Those showing Type I (treated with serum) nearly all recovered, while those due to Type II and Type III gave a mortality of 53%.

4. Since the object of the serum is to neutralize the soluble poisons in the patient's blood, and since the amount necessary will vary with the amount of this soluble poison, serum must be given *intravenously* and in large quantities.

5. Serum should be administered in all Type I cases at the earliest possible period. Exception: Very small children, adults seen late and with mild toxemia. The administration of serum should not be put off because the case seems mild at the beginning. These are the cases that often give the most severe toxemias after a slow, insidious onset.

6. In rare cases there is an idiosyncrasy to horse serum giving rise to very severe reactions to the intravenous administration of serum, and to guard against this occurrence the following technique has been in use:

(a) Intradermal introduction of 0.02 c.c. sterile diluted horse serum in the arm with a similar amount of NS Solution as a control.

(b) In the absence of a persistent wheal at the point of injection after one-half hour, proceed with the injection of serum. If, on the other hand, there is a persistent wheal urticarial in character with erythema, etc.

(c) Desensitize the patient by small s.c. injections of serum at one-half hour intervals and then proceed to give serum as indicated.

7. A certain amount of thermal reaction is to be expected, and according to recent observers is desirable. If, however, the reaction seems too violent, conditions are relieved by an s.c. injection of adrenalin or atropine.

8. A white blood count of 10,000 to 30,000 occurs normally in all lobar pneumonias. A count below 10,000 may mean a very mild toxemia or an overwhelming one. The leucocyte count is of great importance, both as a factor in early diagnosis and an indication as to prognosis. Routine examination should be made on the first and tenth days of the disease and on the first, second, third and tenth days following an operation for empyema. (23) (21).

Routine administration of digitalis from the beginning was advised. The use of serum only after typing had been done and in Type I cases was also urged. Under the above method the mortality in pneumonia had been reduced from 20%+, as held in usual practice (Norris in Osler-McCrea), to less than 8%. The subject of prophylactic measures against pneumonia with vaccines was under consideration with some favorable reports, but nothing definitely practical established.

This briefly summarizes the conclusions as reported by the collaborators at the Rockefeller Institute (32) in the latter part of 1917. Since that time a great pandemic of respiratory diseases has come upon us, and it remains to be seen if the work accomplished during this period has brought us added knowledge in the treatment of these diseases.

First as regards the serum treatment of lobar pneumonia. It has been noted that in ordinary conditions 60% of the pneumonias are due to the first two types of pneumococcus and about 34% to Type I. Avery et al. (32) urged that Type I serum be used only where Type I organism had been isolated. This would naturally limit its use pretty largely to institutions where there are ample laboratory facilities. There were clinicians, however, who urged that since the ratio of probability is in favor of Type I organism, and since there is imperative need of very early administration of serum to get the best results, and

since the administration of a serum (though non-specific) had been used with really beneficial results, for these reasons they urged that Type I serum be used in *every* case of lobar pneumonia whether typing had been possible or not.

Recent findings would tend to substantiate the latter proposition and may be noted as follows:

(1.)—It had already been observed as reported by Avery that lobar pneumonia is often favorably affected by the so-called thermal reaction which takes place after the intravenous injection of foreign proteins, whether in the form of a specific or a non-specific serum or vaccine or bacterial filtrate. This was especially true where there was a very marked reaction with chill, cyanosis, dyspnoea, elevation of temperature of one to three degrees. After such a reaction the temperature often fell to normal and remained there.

(2.)—Cowie and Bevan (2) have made use of non-specific proteins with good results in the treatment of arthritis, and believing that like results could be obtained in pneumonia they tried out this method in an interesting series of cases with rather remarkable results. Lamb and Brenin (22) have also reported favorably on the use of the non-specific proteins, trying out several different varieties, and they definitely state that in no case did they observe any harm from the use of either serums or vaccines, even where the results were not beneficial. Roberts and Cary (1) reduced the mortality in their pneumonia cases from 31% to 9.5%, which compares favorably with the specific serum treatment in Type I cases where the mortality as reported by Avery and more recently by others was 7.5%.

(3.)—The theory behind the use of a non-specific protein is based upon the fact, as shown by Gay and Claypole, that there is an increase in the leucocyte count with (Roberts & Cary (1) an increased production of agglutinins and lysins and an elevation of the opsonin and lysin content in human serum, and consequently an increased liberation of specific antibodies against the prevailing disease even though the protein used be non-specific in character.

(4.)—A fourth fact to be specially noted is that under epidemic conditions Type I pneumococcus no longer predominates, but since Type III and Type IV organisms are normally present in the human mouth it is this type that is always at hand to invade a lung tissue made non-resistant by deleterious gases or influenza, and instead of being present in only 20%, as reported by Avery, it has been during the pandemic just past present in about 80% of the lobar pneumonias reported upon. (35).

(5.)—It is true that the ease and simplicity and lesser expense involved in the use of vaccines or bacterial filtrate as preferred by some observers (2) (22) (1) for administering non-specific proteins would argue in their favor; it is equally true that serum may be equally effective and of very positive value in Type I cases.

It would seem fair to conclude, therefore, that in the absence of epidemic conditions where Type IV organism predominates serum treatment should be instituted immediately the diagnosis is made. First, because if the disease is due to Type I no other treatment is warranted, and secondly, if the disease is due to one of the other types of pneumococcus the serum, the non-specific in this instance, may still set up specific antibodies against the prevailing organism. If the serum is not available, and if other than Type I is suspected the use of the pneumococcal vaccine is warranted, both on the ground of its possible specific action and as a foreign protein, always providing it is used very early in the disease. Its value after the first three days is apt to be nil and its danger is rather positive.

It is true that the general practitioner and the internist with limited laboratory facilities must be at a great disadvantage in the handling of diseases where *very early* bacteriological findings are important. It is equally true that most physicians are inclined to fail in making the best use of the means at their command. No man attempting to do conscientious, up-to-date work in the practice of medicine can afford to be very far separated from his microscope or from his ability to do the routine blood and sputa examinations. In the question at issue the urine or precipitin test for type is within the limitations of most clinicians and it is fairly conclusive, and as to the more complicated bacteriological and pathological work there is a state laboratory well equipped, accurate and prompt in its returns, that is always at our call, and too much emphasis cannot be placed upon the need of making constant use of this almost indispensable aid to the efficient handling of our medical cases. A carefully collected specimen of sputa forwarded at the time of the first examination with a request for "report by wire" should secure a response in time to make effective treatment, and in the meantime a single injection of Type I serum can do little harm (35) other than to the patient's pocketbook and may do a great deal of good. In the meantime, also, the urine test may readily give the desired information. "On your toes" is as good a slogan for the physician as for the major league second baseman.

THE CARDIAC PROBLEM IN PNEUMONIA.

Two problems other than serological have been given much attention in their relation to lobar pneumonia, and demand special consider-

ation, that is the cardiac condition and acidosis. The best means of managing the heart to "tide over" the crisis in lobar pneumonia has always been a bugbear to the physician. Some have urged the use of so-called "heart stimulants" from the beginning in an effort to "tide over"; others have held that all heart medication should be held to the time when it specially needs help, that is, just previous to and following the crisis. It is only comparatively recent that a careful digitalizing of the patient has been advocated with the view of so conserving the heart as to keep it in a state of constant efficiency throughout the entire period. Cohn (36) called attention to the action of digitalis in pneumonia in 1917, and most writers report having specially digitalized their patients during the epidemic. (17). The advisability of such a procedure is emphasized by the discovery of the radiologists that the heart is always enlarged in lobar pneumonia—to such an extent, in fact, that it is a strong point in early diagnosis of pneumonia on the part of the radiologist. Digitalis would seem to be one of the few drugs of proven value in pneumonia.

AVOIDANCE OF UNNECESSARY DRUGS.

In the consideration of the heart it is well to note the proven inefficacy of most drugs used by the medical profession, as reported by recent writers. The effect of so many reports along this line is like the action of digitalis itself, cumulative, and it would seem conclusive.

Small and Blanchard (24) specially mention the uselessness of aspirin, aconite, sodium salicylate, belladonna, quinine, and Dover's powder, but speak highly of gelsemium and of digitalis, strychnia, adrenalin and caffeine to aid in the cardio-respiratory function. Lamb and Brennin (22), Roberts and Cary (1), Cowie and Bevan (2), and Goodkind (5), all digitalize their patients, and the latter especially mentions the value of camphorated oil hypodermically, which is so popular as to be almost in universal use among the French physicians.

It would really seem that a few drugs used to effect would be far more productive of favorable results than the use of many drugs of questionable value, and that in general the fewer drugs used the better, lest what is intended as an aid become a burden to a laboring heart and overworked eliminative organs. Measures preferable to drugs in beneficial results may often be adopted to the advantage of the patient and to gratitude of an already overworked gastro-intestinal tract.

VENESECTION.

In those cases where there is plethora, a rapid, full, bounding pulse, cyanosis, dyspnoea or air hunger, indicating not only that the air vesicles are filled with an overplus of blood and mucous, but that the

point has been reached where acute dilatation is imminent, venesection is, in the writer's opinion, of paramount value. Under these conditions the withdrawal of a pint or even a quart of blood is followed by rather remarkable results. (28).

DRY CUPPING.

Another measure much thought of by the French and much neglected by us is the use of dry cups to relieve pain in the early stages of the disease.

HYDROTHERAPY.

Hydrotherapy is pretty much in general use, but with little uniformity as to technique. It ranges, according to recent reports, from tepid sponging as routine measure to the tub plunge.

Here, as elsewhere, the consensus of judgment will be in favor of a conservative course, limiting the measures adopted from tepid sponging to cold packs always (still in the interest of the heart), avoiding *anything* that can cause exertion or fatigue to the patient.

ACIDOSIS.

The second problem demanding special consideration is that of acidosis. It is well known that acidosis is a usual accompaniment of every marked toxemia, and its close relation to the infectious diseases and bearing upon their mortality should be closely considered.

In 1917 Palmer (34) made a special report on the relation of acidosis to lobar pneumonia, and in a recent interesting paper Ely (37) bases his success in handling "26 lobar pneumonia patients, over 100 lobular pneumonia patients, in addition to a great number of influenza patients, with only one death," largely to the "persistent early elimination and saturation of the system with alkaline (sodium, potassium, and calcium) bases and the avoidance of remedies which check secretions, as opium or belladonna, and of heart depressants, as aspirin." The principles which he advocates are in accord with the best treatment as suggested by other clinicians and impress one as forming a rational basic procedure in the treatment of all the infectious diseases and especially in the treatment of pneumonia, whether of the lobar or broncho pneumonic type. There will be a difference of opinion as to the degree to which sweating the patient, for instance, may be carried, but in general the procedure as outlined looks good. Note the following points:

1. Withhold all food for from 24 to 48 hours and force fluids by mouth and by bowel.
2. Induce perspiration by the use of hot drinks (boneset tea), hot foot bath, warm blankets, and encourage sweating in an effort to

increase the carbon dioxide output (preventive cyanosis) throughout the disease and at the same time to avoid the danger of too rapid oxidation and catabolism by keeping the temperature at a lower level.

3. Further promote elimination by fractional doses of calomel and enemata.

4. Avoid the use of opium or belladonna or atropine or other remedy that, although a stimulant to the heart, tends to check secretions and so lock up in the system poisons that should be eliminated.

5. Alkaline saturation and elimination (thorough) must be combined in order that the products resulting from the combination of the poisonous acids and the supplied bases may be eliminated as fast as formed.

6. Alkaline saturation is accomplished by the administration of calcium in the form of lime water (lime water $\frac{1}{2}$, milk $\frac{2}{3}$), of potassium citrate ($\frac{1}{2}$ to water $\frac{1}{2}$ iv—administer $\frac{1}{2}$ 1 every two hours, alternating with an equal amount of sodium bicarbonate, same proportions, in peppermint water), and of sodium bicarbonate given by bowel every four hours.

7. Substitute dry cupping for aspirin or opiates to relieve pain.

8. The withholding of food for from 24 to 48 hours and the giving of large amounts of fluid by mouth and the flushing of the colon by enemata is strongly advised by various authors. In the alkali treatment this procedure is of special value, it is claimed, because a large amount of fluids facilitates the neutralization of the poisonous acids and tends to flush out the waste products from the liver, pancreas and kidneys. Ely specially notes that no matter how much fluids are injected it is skin and kidneys, and not the bowel that are most active in the elimination.

OPEN AIR TREATMENT.

The question as to what extent the open air method should be employed in the treatment of pneumonia has always been of interest and has come in for more or less experimentation during the past year. The method as carried out at Camp Wheeler (6) was so radical, not to say cruel, and the converse treatment, where measures were equally radical in the exclusion of fresh air, that a fair conclusion in favor of the latter method because of its relative low mortality cannot be drawn. Here it would seem rather a case of unwarranted exposure as opposed to equally unwise over-coddling with the chances of recovery in the favor of the latter. The consensus of judgment is in favor of *fresh air* all the time, with ample protection against undue exposure or exertion or fatigue.

VACCINE THERAPY.

Experimentation at Camp Upton, as reported by Cecil and Austin (39) with the use of vaccines composed of Types I, II and III pneumococcus gave very favorable results. More than 12,000 men were vaccinated, with a decided lowering of incidence of pneumonia due to these types of organism.

Further experimentation was carried out at Camp Wheeler (40) between Sept. 21 and Dec. 20 of the past year, during which time nearly 14,000 men were vaccinated. The incidence of pneumonia among 13,343 men who had been was 26.1 per 1,000, as against 68.3 per 1,000 among 3,378 who were unvaccinated, and among seasoned men the rate among the vaccinated was 7.2 per 1,000 as against 46.4 per 1,000 among the unvaccinated.

These facts speak for themselves as regards the use of Lipo vaccines in the future in army life, but to what extent they may be made practicable in civil practice remains to be seen.

The use of vaccines as a therapeutic measure in lobar pneumonia has been in vogue to some extent for several years. Personally they have been used with very favorable results, but always very early in the disease. Results when used at a later stage are not satisfactory. Too frequently they have been used only as a last resort by those not fully appreciating the danger, and disaster has followed. When used *very early* in selected cases they may be of great value. Whether the sometimes magnificent results are due to their specific action or to their action as a foreign protein is not positive, but there is a growing feeling that both as a prophylactic measure and in treatment, if used very early, the vaccines are of distinct value.

COMPLICATIONS.

Under complications of lobar pneumonia to be considered, abdominal distension and empyema have occasioned most frequent comment. The treatment of distension should be confined chiefly to its prevention, since it is not only most distressing and exhausting to the patient but a distinct source of danger. The early and persistent use of enemata as outlined in the treatment against acidosis will usually suffice to prevent this complication, especially if combined with avoidance of the opiates. In active treatment the rectal tube and the turpentine stoop are of value, and the following enema as used at the Rockefeller Hospital should prove effectual: Ox gall 4 c.c., turpentine 8 c.c., asafoetida 12 c.c., soap-suds 1 pint. This should be given high and followed in an hour with 1 pint warm suds.

EMPHYEMA.

Few measures, if any, in the way of prophylaxis have proven effectual against empyema. Very early diagnosis and early treatment of the disease itself with serum or vaccines must be the chief hope of the physician. Even under the best conditions the incidence of this complication to pneumonia is far too frequent for the peace of mind of the doctor.

Schorer (21) reports 81 cases of fluid in chest (56 purulent) in 181 cases of pneumonia (151 lobar and 28 broncho); 34% of the straight pneumococcic pneumonias and 37% of the streptococcic pneumonias were complicated by chest fluids (25% purulent).

Gray (23) reports 77 cases of empyema in 485 cases of pneumonia (88% lobar) with a mortality of 44%.

Difficulty in early accurate diagnosis has been emphasized by several writers. Out of 77 cases reported by Gray (23) 17 were missed, and that under the best possible conditions for accurate early diagnosis. In one set of cases, five out of seven cases were missed.

The Luer or aspirating needle usually proves conclusive, but failure to find the fluid with the needle is far from being final. It was used routinely in Gray's cases, and the writer has seen one case recently in one of our best and largest New England hospitals where five competent physicians, one after the other, failed to find fluid, although clinical signs were present and the X-ray was positive. Operation revealed a large amount of pus in precise position indicated clinically and by X-Ray. The X-Ray is of inestimable value where it can be utilized for diagnostic purposes and should give positive findings of chest fluids sooner than they can be detected by clinical methods. (42).

The leucocyte count is another important factor in early accurate diagnosis of empyema as well as an indication of prognosis. It is advised that a routine white blood count be made on the first and tenth days of all pneumonias and on the first, second, third and tenth days after operation for empyema.

The mortality in empyema complications depends largely upon three factors: (1) time of onset, (2) whether bilateral or unilateral, (3) operation. In Gray's cases (23) empyema occurring in the first week were 41% fatal, in the second week 26% fatal, and thereafter 7% fatal. Operated cases gave a mortality of 21% as against a 70% mortality in the unoperated cases.

TREATMENT OF EMPYEMA.

The following points will summarize the conclusions as recently expressed by various authors relative to the treatment of empyema.

1. Operation is always indicated where there is pus.
2. Too early operation is not advisable. Cases operated in first 24 hours after diagnosed (if very early) apt to prove fatal. (23).
3. In the presence of fluid, aspiration should be done, and where pus is present it is wise to aspirate again before operating. There is less shock and less danger.
4. In case the streptococcus is present in the fluid, rib resection is the operation of choice (43), but where the pneumococcus alone is present there is a difference of opinion as to whether thorocotomy alone or thorocotomy with resection should be insisted upon.
5. Rib resection may readily be performed under local anesthesia without undue shock or distress to the patient. [Case presented.]
6. The successful uses of so-called "closed methods" of treatment have recently been reported upon (44) (45) (42) and in the hands of the originators are apparently an improvement in many cases over the usual open method. But while Beck (42), in a recent paper before the Western Surgical Association, mentioned one of these methods as the ideal method of drainage he placed rib resection under local anesthesia performed at the eighth or ninth rib posteriorly as the operation of choice. He also stated that "repeated punctures and repeated withdrawal of small quantities of fluid *might* cure empyema" and that rib resection should be performed only after the secretion had become distinctly purulent.

This, in general, fairly covers the data relative to lobar pneumonia as regards its causation and treatment. It is not a single disease, but a group of diseases. Two of the four types of pneumococcus are found normally in the human mouth, while the first two are found only when associated with disease (41). The only specific treatment of pneumonia is that of the pneumonia due to Type I organism. Otherwise the treatment must be more or less empiric. The reactions due to the different groups of organisms differ and the relative frequency of each type differs with prevailing conditions.

To build up from the data at hand a precise program for the treatment of lobar pneumonia that will meet all requirements is not possible, but there are certain basic cardinal principles in the treatment of pneumonia upon which we may at least establish a rational working basis. Such a program will embody the following essential points.

1. That fresh air all the time, with careful protection of the patient from undue exposure, is far better than canned oxygen at a fatal end where its chief value lies in its psychological effect upon the relatives and friends.

2. That special attention be given to the prevention of acidosis from the very beginning (*a*) by withholding all food for from 24 to 48 hours, (*b*) by encouraging the intake of large quantities of fluids—water, barley water, orange juice, lemonade, clear soups, milk and lime-water, etc., (*c*) by the induction of free sweating at the beginning of the attack, (*d*) further elimination by use of calomel in fractional doses and flushing of the colon, (*e*) by the avoidance of drugs that check secretions or that (*f*) depress the heart, (*g*) and by the careful administration of sodium, potassium and calcium by mouth and bowel in such quantity as is necessary to produce the degree of alkali saturation desired.

3. That a skillfully and scientifically managed heart in lobar pneumonia is a big asset toward recovery, and that such management involves (*a*) its careful digitalization, (*b*) the use of only such drugs as have proven of value, as strychnia, caffeine, camphorated oil, adrenalin, and (*c*) by the skillful use of hydrotherapy so managed and controlled as to meet the needs of each case without causing exertion or fatigue on the part of the patient, but to act as a restful, quieting tonic to both heart and respiration.

4. That with a full pulse and an engorged lung, bleeding is a life-saving measure when all drugs will fail.

5. That dry cupping is just as effective for the relief of pain as it was 50 years ago, even if it is old-fashioned, and is much preferable to opiates if effective.

6. That heroin *sc* is far better for the patient than opiates by mouth.

7. That successful use of either serum or vaccine depends largely upon an early diagnosis, and that such diagnosis will often tax every resource at our command. It is too late to wait for all the classical signs of chill, fever, rusty sputum and a consolidation that the finger can detect. The X-ray, where possible, and as opposed to broncho pneumonia the more rapid pulse and respiration, high white blood count, dry cough, and special attention to the "rales on cough" test (23) and the whispered pectoriloquy depended upon so much by Cabot should give sufficient data for such early diagnosis as good management demands.

8. That the determination of type is not easy but should be made if possible, paying strict attention to the securing of a proper sputa specimen (require the patient to cough for at least three minutes by the clock in the early morning, using the fluid portions coming from the deep lung) and making the urine test as a routine.

9. That the treatment of pneumonia due to Type I organism is specific in character and should be administered intravenously as early as possible, gravity method, with previous precautions against serum idiosyncrasy.

10. That where serum treatment is not practicable the anti-pneumo-streptococcic vaccines are indicated, providing they are used very early.

11. The last platform in the program against pneumonia, involving as it does the complications, their avoidance and treatment, is by no means the least. In the management of abdominal distension and of empyema outline has already been made as to the procedure most favored in the recent literature bearing upon their management.

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DISCUSSION.

THE PRESIDENT: The discussion of Dr. Powell's paper is now open.

DR. STURGIS: Mr. President, I was pleased to hear this paper. It was my privilege, through the kindness of Dr. Twitchell, to be at the table last evening with Dr. Towne, whom I wish could be here and speak to you as entertainingly as he did to me last evening on this subject. Dr. Towne was in France in one

of the big base hospitals, and he spoke of some things that the writer of the paper did not mention, to my knowledge, and I followed him as closely as possible. One was that over there in France in that base hospital at the time, they found that the best thing in that climate was the use of the so-called 2-4-6 combination (that was two grains of Dover's Powder, four of phenacetin and six of aspirin), and also some form of the digitalin preparation was begun early to support the heart. This 2-4-6 treatment was continued for two or three days at very close intervals. The next thing they followed that with, and seemingly with great success, was the carbohydrate treatment. All he said to us was that in this carbohydrate treatment that they should be fed all that they will take. The only limit was what the patient could get inside of him. He also told us of the extensive use of cupping by the French, and said that in some cases they carried it to ridiculous extremes.

DR. MORRISON, of Bar Harbor: Mr. President, during the recent epidemic I was at the Washington City Hospital, and this paper in regard to the treatment of empyema was interesting to me. I was wondering if any others had any statistics, particularly with reference to the syringing out of the chest cavity with Dakin's solution. As regards the other treatment by rib resection, I wonder if anybody else could give any statistics on that?

DR. SMITH: Mr. President, there were two things that I wish might have been brought out more fully, and one is early diagnosis of pneumonia. It is always possible to diagnose it in my experience. The other thing is that in my opinion rest of mind and rest of body has done more good than all the medicine I have ever given in pneumonia.

DR. JACKSON: Mr. President, I am unable to answer Dr. Morrison's question positively. I have had some experience with Dakin's solution, but I would like to ask some questions on it. I did not hear Dr. Powell's paper. The doctor said that they had very satisfactory results in those cases in which they used Dakin's solution in the cases of empyema in which the fluid was of the serous type. An unfortunate thing is this, that the early empyemas are of that type, and it has been my experience that an operation of that type, if the pneumonia is active, will result in harm—not in all cases, but in a large majority. Of the cases of empyema that we see, usually following a pneumococcus infection, there is a large amount of fibrin and the pus is of the heavy type. Now I am unable to understand how a simple trocar method of operating, unless the operator is satisfied that his Dakin's solution will dissolve that heavy deposit of fibrin, and also absorb or digest, if you please, the heavy pus, is going to give us the best results. I can remember one or two cases that I operated on following this epidemic, and it seemed to me that it would almost have been impossible for any other operation besides a wide resection of the rib to accomplish the result, for the simple reason that the pus was not fluid, but was in large, heavy masses. I removed at least two quarts from one woman, taking out large, cheesy masses directly with my hand. I would like to have some of these army men inform me if in those cases they found the trocar method of operating on empyema satisfactory. It seems to me that Dakin's and the hydrochlorids would be of advantage there.

DR. CALL, of Lewiston: Mr. President, I don't know as I just got the question of Dr. Morrison, if any statistics could be quoted to answer his question. I attended the Massachusetts Medical Society, and one of the papers I heard was

in regard to the removal of pus in the chest cavity. I am saying "pus", for that is what I mean. This doctor had operated on thirty-six cases by putting in the catheter and extracting the pus. Out of those thirty-six cases, he had to operate finally by the old method of taking out the rib in what I considered a very large percentage of the cases. I would certainly like to hear some of the personal experiences that we have all had with this disease this winter. One of the points made by the reader of this paper which I wish to emphasize is the danger of giving any form of an opiate in certain cases of pneumonia, or in some of the serious cases, to relieve pain. I have seen very sudden and serious results occur from it. For treatment, I have seen great relief, in my personal cases, come from attention to the position of the patient, to say nothing about fresh air. I am inclined to elevate my patient slightly and change his position frequently. I find that it relieves congestion. He breathes easier and I have had good results from that.

THE PRESIDENT: Is there not someone here who can answer Dr. Jackson's query?

DR. SYLVESTER: Mr. President, one case occurs to me that I will give. My work was all in tuberculosis, of course, but I saw the results of a good many cases of pneumonia that came up in our tuberculosis hospital. The case which Dr. Jackson had in mind was this: When I came to my present post I took the acute service over. One man had been having injections for several weeks for empyema given daily. That did not sound very well to me, and I found that at that time there was absorption and he was dying. After about a week of my insistence, the surgical department did a radical operation, and found when they got in, not only pus (which surgeons are accustomed to find), but found a tuberculous status, so that six ribs were removed, taking almost the entire breast wall back of the axillary line. It seemed that the man was going to die, but I have the satisfaction of assuring you that he is now gaining in flesh and doing so well that he will make a recovery unless the further absorption of bacilli continues. Now, the point that I wish to make is this: The efficacy of Dakin's solution gets into a man's mind until he forgets some other things. Common sense in surgical treatment after all is necessary. In this case, here was a man who at least for a month had been absorbing pus from pockets in the pleura, ribs becoming affected, showing all the signs of pus absorption, but they were giving Dakin's solution every day, were contented with washing him out, feeding him and giving him sunlight. The surgeon, however, very quickly demonstrated what was needed. This is only one illustration that I wish to make.

DR. STEVENS: Mr. President, the reference that they give here to the Carrell-Dakin method seems to be misleading from my conception of it. I have talked with some army surgeons, one in particular who was at Camp Oglethorpe, and who took a special course at the Rockefeller Foundation, and he said he operated on 300 empyemas. I did not understand that there was a small incision made in the chest and then an irrigation made in that way. I understood it was an operation, and that the solution was carefully prepared by the chemist and that it was administered in a skillful way—not a haphazard injection of it into the chest, but an application of the solution directly to the diseased surfaces in there. The doctor impressed me with the idea that that was what he was taught to accomplish; that without that solution being in contact with all the diseased surfaces inside the chest you get no results.

DR. JACKSON: I would like to correct Dr. Stevens right away; that is where the trouble comes. The gentlemen who use Dakin's solution do not make the ordinary operation for empyema. That operation is made with the trocar and you endeavor to keep the cavity free from air. The trick is in putting in the trocar. You do not allow any air to get in. You let the pus come out through this cannula with the tube attached to it and for three or four hours they inject Dakin's solution. Now the idea that these men entertain, I suppose, is that this is one cavity. They forget that a fibrous pleurisy can make several cavities, and Dr. Sylvester answered the question very nicely. These men claim that we should not resect the rib. We should make a puncture between them, keep the cavity free from air, express the pus by means of a suction apparatus, then inject your Dakin's solution. You are supposed to find out by physical examination and by the X-ray when your pus is free and the lung is expanded.

THE PRESIDENT: It is very interesting to know of the use of dry cupping in these camps in pneumonia, particularly to the followers of Drake and Loomis. Thirty-five years ago this was the favorite method of relieving pain, and particularly of relieving the embarrassment of the right heart near the time of the crisis. I will ask Dr. Powell, when he gets to the time of closing the discussion, what course was pursued if in case of an unrecognized empyema there came a relief of that empyema by discharge through the bronchus? If the X-ray findings show fluid still there, do they immediately operate or do they give an opportunity for the pus to still escape from the bronchus? There were a great many cases of unrecognized empyema throughout the country that got some relief through the bronchus. Is there any further discussion?

DR. TWITCHELL: Mr. President, I do not know of any surgical trouble that is more easy to cure by the ordinary method than empyema. I do not think it does a bit of harm to get air through there. I never have seen any trouble in curing empyema by the ordinary method unless the patient was so septic before I got at him that nothing would cure him.

DR. SMITH, of York: Mr. President, I would like to ask how long a time it takes by the Dakin method to cure one of these cases?

THE PRESIDENT: Dr. Powell will take that up in his reply, and if there is no further discussion will Dr. Powell close it?

DR. POWELL: Relative to Dr. Sturgis' remarks in regard to the treatment used in the base hospitals in France, I want to say that after sixteen months living in the vicinity, rather in the front portion from the base hospitals, and after spending nine weeks as a patient in one of the base hospitals, I did have an opportunity to observe a good many different methods of treatment. I saw some of the best work that I have ever seen anywhere in my life, and I have seen some of the roughest work that any member of the medical profession could be guilty of perpetrating upon an innocent victim in some of the hospitals in France. I regret to say it, but it is true; not always on account of inefficiency, but sometimes on account of the great overcrowding. I have been in pneumonia wards when patients were dying so fast that it was almost impossible to take care of them. I have gone into wards where one nurse and two or three inexperienced boys were trying to care for these men. The nurse would say, "Doctor, I don't know what to do. I have lost ten men this morning, and ten more will certainly die before night." You will find that sort of thing as opposed to the other sort of thing where they did have magnificent treatment.

I have seen the French use the dry cupping a great deal with mighty good

results, and I have seen its use absolutely abused, as you will see any good treatment abused. Well used, it really impressed me as being very effective where brains were mixed with the treatment.

The 2-4-6 treatment I have never seen used. Personally, I would not approve of it for a moment, because I believe it is against the a-b-c principle upon which the treatment of pneumonias should be based. It depresses the heart and depresses the general condition to an extent that would seem to me unwarranted.

In the use of Dakin's solution I will have to disagree a bit with Dr. Jackson. I think the value of it is greatly overestimated, both as to the treatment of wounds as well as pneumonias. Those who use the Dakin method with wonderful results are great for it, and those who have not had good results are rather opposed to it. It is claimed to be valuable in bringing down the fibrin that is massed within the pleural cavity, and that is one of its chief reasons for use, as I understand. My work has been on the front line and not in handling those patients, so what I say is largely from observation and reading only.

As regards the closed method of treatment, I think it has been used too little to give us a definite feeling that it is the best method. Personally, I did a rib resection on a soldier just a few weeks ago. I had a good mind to bring him here this morning. He was a very sick man. The rib resection worked beautifully. I did it under local anesthesia. He had very little trouble and the drainage was entirely cleaned up in three weeks.

In answering the last question as to the period of time, if I remember correctly the reports give the best termination as in about ten days, and I remember a good many of the cases had not closed at the end of four weeks, and some of them not after that.

The question as to the abscess of the lung when the fluid breaks through into the bronchus, I think that is a question of degree. It may not have been a general pleural effusion and the breaking through into the bronchus may clear the condition entirely. If the X-ray and clinical condition show such a condition, I think the consensus of opinion is that free drainage by anterior and posterior incision would be wise. [Applause.]

***EDUCATION AND RECREATION IN THE ARMY.**

By MAJOR GENERAL WILLIAM G. HAAN, Assistant Chief of Staff, and in charge of education and recreation work in the army.

That education and recreation as applied to the new army has passed the experimental stage and is now a vital factor in the training of the soldier was shown at a convention of army educational officers, held at Camp Zachary Taylor, near Louisville, Kentucky, on December 9, 10 and 11.

Early in the year the War Department, actuated by a deep sense of responsibility felt towards the millions of men brought into the service during the war, as well as by the astounding facts as to illiteracy and physical condition of the young men of the country as shown by draft statistics, and the excellent work done by the Commission on Education and Special Training, had conceived an army built up on a new plan. It was proposed to make the army not only a military force to be trained and ready in time of national emergency, but a great educational institution where young men of the best mental, moral and physical conditions, and with the highest ideals of patriotic citizenship, would be produced.

This plan was realized, in a measure, when Congress appropriated the sum of \$2,000,000 to be devoted to this purpose during the fiscal year 1920. Accordingly, in September of this year, instructions went forward to the commanding generals of all divisional camps and of territorial departments, who at once appointed on their staffs officers known as Education and Recreation Officers to assume direct charge of the work. Each officer has associated with him at least one civilian expert in educational affairs, who furnishes assistance and advice in establishing schools and manual training classes.

But it remained for the Camp Taylor convention, called by the Secretary of War in order that the work in general might be co-ordinated and rough places smoothed out, to show that the army is now in reality a great training school where the mothers of our young Americans will be glad to see their boys go. This idea of the army as a vast university in khaki is admittedly hard to conceive, but nevertheless the thing has been accomplished right before our eyes.

No longer is the army merely concerned with the making of a recruit into an efficient fighting man, by giving him the prescribed system of military training only for a few hours of the day and leaving him almost entirely to his own resources for the remainder of the day. It now assumes responsibility for the entire twenty-four hours

*Authorized by the office of the Assistant to the Secretary of War, Service and Information Branch.

of his day, and sees that every portion is gainfully spent in useful study or helpful recreation. In the soldier's life, education and recreation now have equal places with military training, and are definitely scheduled in the programme of daily work.

All training, whether purely military or educational, has as its main object the development of the soldier's mind to make him a responsible, thinking human being. Every soldier, however poorly he may be educated, or however limited his experience, has still a thinking mind, and that mind is active practically all the time. Such a man is perhaps incapable at the moment of looking at affairs in a broad sense, but the object of all training must be to guide that mind in the direction of right thinking. In order to accomplish this the instructor himself must be able to estimate about what are the channels of thought in the mind of the men being trained, in order that he may so conduct his own part of the work as to gain the confidence of the men he is instructing or leading.

In developing the soldier's mind the most rapid progress is made by placing upon the man, as early as practicable, as much responsibility as he can stand. This placing of responsibility on the man stimulates his pride, raises his self-respect, and urges him to better effort. This is applicable in all kinds of training. It is character building, frequently called moral training, and the most effective means of stimulating self-development.

Every soldier, down to and including the last recruit, will sooner or later become a leader in a smaller or greater sense. In battle, as battles are now necessarily conducted, direct responsibility very frequently goes out of the hands of the officers, and small groups of men must accomplish objectives by themselves; hence leadership must be assumed by some or all of these men. Any one of them may be placed in a position where he must act independently and make his own decision on his own responsibility, which requires thinking and acting on his own judgment. It requires leadership. And it is to develop these latent qualities of leadership that this educational programme has been inaugurated.

New recruits are inclined to look on their officers from the very beginning with respect and as thoroughly conversant with their duties. It is very important that this natural impression should be maintained and improved, but this cannot be done unless the leaders are in the habit of thinking correctly and justly in all matters, and acting accordingly. This is necessary to gain and maintain the confidence and respect of the men. When it has been fully accomplished, then most of the small difficulties disappear. There will be a high

state of morale in the command, and wherever we find a high state of morale we always find a high state of discipline, instruction and consequent usefulness.

Officers of our future armies will be required not only to be thoroughly trained in a professional sense, but must also have that human quality which comes only through a real interest felt for the welfare of the men under their command. They must not only be military instructors to the men, but also their leaders in all sports and recreation. Experience of the larger colleges and universities has shown that a certain amount of sport and recreation is a necessary part of the student's life, and as the army is now a great university in every sense of the word, and each man composing it a student, recreational activity will be a part of its training. Here the army chaplain enters as an important factor in the handling by military means alone of all the camp activities formerly furnished by the Y. M. C. A., Knights of Columbus, etc., and the Americanization of aliens in the army.

Under the system of education now in force it is possible for men to receive instruction so as to fit them to be carpenters, blacksmiths, pharmacists, dental assistants, engine workers, mechanics, draftsmen, stenographers, truck gardeners, motor drivers, repair men, telegraphers, radio and telephone operators, etc. Such educational subjects as English, geography, mathematics, United States history and modern languages are also taught. Of course, at the present stage of the game, it is not possible to give instruction in all subjects at any one camp or post, but so far as practicable the desires of the enlisted man as to the courses to be taken by him will be met.

A certificate will be given by the local commanding officer or school officer to each man who successfully completes a course, indicating that he has satisfactorily completed the course studied. A standard War Department certificate will later be adopted, and the possession of such a certificate by a soldier who has been discharged with a character of "Excellent" will be sufficient recommendation to a civilian employer as to the qualifications of the discharged soldier for employment.

On the other hand, it is highly important that the men themselves take the thing seriously and realize that the government is concerned not only in making trained soldiers of them, but also making of them self-supporting and self-respecting members of the communities to which they will return on discharge.

This work is unique in the history of the government, and highly important in showing the trend of the army in facing the new problems developed by the World War. It will result in making the army in time of peace a more valuable factor in the life of the nation by producing men of best possible type, having a good general education, possessing a useful trade, but, above all, thoroughly trained in moral character and the duties and responsibilities of good citizenship.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

IDAHO MEDICAL LAW.

We note from *Northwest Medicine* the following account of the latest medical law in Idaho. ✓

All new forms of legislature are first tried in the newer states of the far west. So far as licensing of physicians is concerned Idaho can qualify in this classification, for the legislature has just abolished the Board of Medical Examiners and transferred its duties to the Department of Law Enforcement, the commissioner of which is empowered to appoint an advisory committee of six licensed and reputable physicians, a majority of which shall not be representatives of any one school, and amongst whom three schools of medicine shall be represented. Those physicians already licensed can practice without further examination, but all applicants shall be examined on the theory and practice of medicine and surgery, or either of them, as taught in the chartered school from which they were graduated. Other subjects are specified as ordinarily included in such examinations. The definition of medicine covers practically every possible means of treating the human body. All who practice any of these possible items shall be regarded as practicing medicine and surgery. Reciprocity is provided for in ten Pacific states, but all the rest are omitted. All persons required to obtain licenses from the department must have their license renewed every year at a cost of \$2.00.

As *Northwestern Medicine* says, "In many respects this act contains some of the most curious provisions yet made in any medical practice act yet passed by any legislature." The first examination will be held October 7.

In conclusion we note that a recent optometry bill was vetoed on the ground of being unconstitutional, because it licensed all former optometrists without any examination as to fitness. The courts held this to be correct as to law, because no fitness could be proved without an examination. No matter how long the optometrists exempted by the bill had done refraction work, they must furnish proof of knowledge.

This gives us food for thought in Maine.

TO THE COUNTY SECRETARIES FROM THE NECROLOGIST.

The office of necrologist of our association is no sinecure, but something difficult. It looks easy enough to suggest to this official that all that he has to do on the death of a member is to get a newspaper cutting and make out of that a life for the JOURNAL. But we ask, how can the necrologist keep the run of members dying in every county in Maine? It ought to be the duty of the county secretary to keep note of deaths, and to try to help the necrologist, not only with a newspaper cutting of such facts, but with a half-tone block of the deceased member. Many secretaries do good work in sending in the cutting, but they all seem to think that the JOURNAL can print a portrait from the print of a half-tone block as done by the newspaper. But such a thing cannot be done, and the JOURNAL wants the loan of the half-tone block itself from the newspaper in which it was printed. In that way we save money for relatives and for the association.

In addition, now, to a cutting and a half-tone block, the secretaries could be of great service to the necrologist by writing briefly concerning deceased members. It takes no literary ability to say that a member attended meetings faithfully, read a paper once in a year or two as requested, always had cases of value to report at meetings, liked to tell his experiences with cases like those reported by other members, and in actual fact took a sharing part in all of the discussions. If the man were a silent member, it could so be said of him. Did he tell a story fit to be printed? If so, can that be sent in also? It is useless to say that a man was a good story teller, if something cannot be handed in as proof thereof.

Now the necrologist thanks the secretaries for much help in the past, and hopes by these suggestions to obtain wider help in the future

for composing brief biographies of deceased members whom we are sorry to lose, but do not forget, first, last, and always, that a newspaper life composed by a reporter is by no means any sort of a reflection of the medical career of members who fall from our ranks from time to time. All of them deserve some notice, so let us united make it as faithful as we can.

THE STRING TEST IN PEPTIC ULCERS.

After further experiences with twelve years of practice and some hundreds of cases Einhorn is of the opinion that the duodenal bucket or string test has amply proved its value in practice. He advises it at bedtime, uses a string thirty-two inches long, and takes care that no food is taken, such as coffee, claret or jellies, which might stain similarly to blood, and lets it remain *in situ* all night long. In a given thousand cases, nearly five hundred were positive; the rest were negative. He concludes that it is useful in locating the position of the ulcer, whilst patency or stenosis of the pylorus are also testified to. It often points most certainly to a correct diagnosis and a proper mode of treatment.

In a discussion following the reading of this paper, some speakers thought that stains had been found in which the existence of the ulcer was disproved, some did not always favor the bucket attached, others thought the string itself enough, and some members favored X-ray diagnosis as the safer and surer. Much discussion was given to the sort of string to be employed, and braided silk was considered the best. The bucket, which in the writer's opinion proved the permeability or impermeability of the pylorus, a point of much importance in treatment, ought to be used oftener than generally is the case.

POSITIVE WASSERMAN IN CASES NON-SYPHILITIC.

Attention is now and then called to the curious question of the positive diagnosis of syphilis by a positive Wasserman reaction, and in similar trend of thought we note that Biggs, in the *Missouri Journal*, calls attention to a very considerable number of patients in whom no trace of history of the venereal could be discovered in any way, shape or manner, but all of which nevertheless revealed a positive blood test over and over again. Curiously enough, all of these instances were in women between 35 and 60, and all of them suffered from hyperthyroidism and various eye signs of important value. During a subsequent discussion of Biggs' paper many similar instances were

reported, and the discussion finally wavering off into treatment, much doubt was thrown on the final cure of the venereal by any of the modern synthetic compounds in comparison with those long since obtained, and many of them steadily maintained for long years of observation, by mercurials.

MEDICAL DEFENSE IN MINNESOTA.

✓ We continue from time to time to present brief annotations concerning the invaluable topic of medical defense against malpractice suits, hoping in due season that Maine will adopt it as many other states have done and find it of decided value. We note in this respect that in a late number of the *Minnesota State Journal* it was said that the State Medical Defense Association has successfully defended all the malpractice cases brought against members, including X-ray cases, except two obstetrical instances in which the infants were grievously burned by coming into contact with an uncovered hot water bag, and an uncovered and heated flatiron, both of which had been placed in the mother's bed. In these cases the court held to the doctrine of the so-called "Sponge Cases," and held the physician liable for the care of the child, even if others handled the water bag, flatiron or other instruments occasionally injuring the infant.

It is well for us to recall to the mind of every physician or surgeon all of these minutiae of practice, in order that they may escape the far-reaching arm of the law.

NEWS ITEM.

The Abbott Laboratories of Chicago have been using half page space in this JOURNAL. Their success warrants them in using a full page at this time. This evidence that the readers of this JOURNAL are careful to patronize our advertisers is gratifying, and it is a tribute to the policy which this JOURNAL long since adopted, of publishing in its advertising pages only such medical products as have been accepted by the Council on Pharmacy and Chemistry.

The readers have come to know that this JOURNAL protects them; and as a consequence they may unhesitatingly purchase the products which are advertised in this publication.

In answering the Abbott advertisement, each reader should use the coupon attached to the page advertisement, so this JOURNAL will receive credit for the inquiry.

County News and Notes.

CUMBERLAND.

CUMBERLAND COUNTY MEDICAL SOCIETY.

The fifty-first stated meeting of the Cumberland County Medical Society was held December 12, 1919, at 8.15 P. M., at the Congress Square Hotel. This was the annual meeting for the year and was called to order with Dr. L. B. Hatch, President, in the chair. There were present seventy members.

The records of the previous meeting were read and approved. The annual reports of the Secretary and Treasurer were read, accepted and ordered to be placed on file.

Upon motion of Dr. W. L. Cousins, it was voted that the portion of Chapter I, Section 1, of the By-laws, requiring one year practice of medicine in the county, be suspended while the names of the following be acted upon for membership: Dr. L. T. Thaxter, Dr. B. E. Moulton, Dr. N. S. Kupelian, Dr. G. O. Cummings, Dr. R. B. Josse-lyn, Dr. M. C. Moulton. It was then voted that the Secretary cast a ballot for the foregoing applicants and Dr. Eva A. Adams and Dr. S. E. Vosbuhre, all of whom were elected to membership.

The following applicants for membership were received and referred to the Board of Censors: Dr. Thomas C. Wyman, Dr. J. R. Hamel, Dr. R. F. Goodhue, Dr. T. A. Foster.

The election of officers for the year 1920 was as follows:

President—Dr. F. J. Welch.

Vice-President—Dr. Daniel Driscoll.

Secretary and Treasurer—Dr. E. E. Holt, Jr.

Censor for Three Years—Dr. N. M. Marshall.

Delegates to the Maine Medical Association—Dr. F. Y. Gilbert, term expires 1921; Dr. F. N. Whittier, term expires 1921; Dr. R. B. Moore, term expires 1921.

Dr. Charles H. Lawrence, of Boston, addressed the society on "Internal Secretions in General Medicine." In an unusually comprehensive manner the varied conditions arising from these disorders were described and illustrated by reports of cases. Many members

took part in the discussion which followed, after which a rising vote of thanks was extended to Dr. Lawrence.

Voted to adjourn. Adjourned.

E. E. HOLT, JR.,

Secretary and Treasurer.

YORK.

YORK COUNTY MEDICAL SOCIETY.

The ninety-ninth quarterly meeting of the York County Medical Society was held in the City Building, Biddeford, Wednesday, Jan. 7th, with Dr. Frank W. Smith, of York Village, the Vice-President, in the chair. The forenoon session was opened at 11.45 o'clock.

The minutes of the October meeting were read and approved.

Dr. Carl G. Dennett and Dr. George R. Love, of Saco, and Dr. Arthur J. Stimpson, of Kennebunk, were elected to membership.

A committee, composed of Dr. J. D. Cochrane, Saco, Dr. C. F. Traynor, Biddeford, and Dr. A. L. Jones, Old Orchard, were appointed to present resolutions on the death of Dr. Charles W. Pillsbury, of Saco. Dr. Cochrane read the following resolutions:

WHEREAS, Under the Divine Providence, our fellow member, an ex-president of this society, Dr. Charles W. Pillsbury, of Saco, was removed from us by death Dec. 3, 1919, therefore be it

Resolved, That the York County Medical Society, in common with this community, has experienced a real sorrow and a great loss in this taking away of a most capable, conscientious and efficient physician and citizen.

Resolved, That the medical profession of this county and state, while recognizing its irreparable loss, will yet find strength, courage and hope in the rich heritage of such a life and character.

Resolved, That these resolutions be spread upon the records of this meeting and copies of the same be sent to the family of the deceased.

J. D. COCHRANE,	} Committee on Resolutions.
C. F. TRAYNOR,	
A. L. JONES,	

Biddeford, Jan. 7, 1920.

It was voted to adopt these resolutions.

Dr. C. F. Kendall, Biddeford, Dr. J. O. McCorison, North Berwick, and Dr. E. C. Cook, York Village, were appointed a committee on nominations, and they reported as follows:

President—Dr. Frank W. Smith, York Village.

Vice President—Dr. Paul S. Hill, Saco.

Secretary—Dr. Arthur L. Jones, Old Orchard.

Treasurer—Dr. Carl G. Dennett, Saco.

Member of Board of Censors for Three Years—Dr. William W. Smith, Ogunquit.

Delegate to Maine Medical Association for Three Years—Dr. Charles W. Bragdon, Sanford.

It was voted to accept the report of the committee and these nominees were elected for the ensuing year.

Dinner was enjoyed at Hotel Thatcher, and at 2.30 P. M. a paper, "Some New Problems in Diabetic Metabolism," was read by Harry S. Emery, A. B., M. D., of Portland, assistant professor of medicine in Bowdoin Medical School. This was an address of special importance on a subject of widespread interest, and it revealed deep study and comprehensive research on the part of Dr. Emery, who presented several valuable case reports and gave an encouraging statement as to the present and future treatment of diabetes mellitus.

Dr. H. H. Brock, of Portland, and several other physicians took part in the discussion that ensued, which proved to be most instructive.

A rising vote of thanks was given Dr. Emery.

There were present the following physicians: H. H. Brock, H. S. Emery, Portland; F. W. Smith, E. C. Cook, York Village; J. O. McCorison, North Berwick; H. L. Prescott, Kennebunkport; B. F. Wentworth, Scarborough; J. D. Cochrane, J. D. Haley, G. R. Love, R. L. Mayberry, P. S. Hill, Saco; C. J. Emery, M. H. Ferguson, E. D. O'Neill, F. E. Small, C. F. Kendall, H. W., Hurd, D. E. Dolloff, C. F. Traynor G. C. Precourt, Biddeford; A. L. Jones, Old Orchard. Total, 22.

PERSONAL NEWS AND NOTES.

The newly invented, very ingenious, and exceedingly useful hand perimeter of our fellow member, Dr. Sylvester Judd Beach, of Augusta, was lately described in full in a worthy paper in the *American Journal of Ophthalmology*. In addition to this, the invention was described by its inventor at a recent meeting of the New England Ophthalmological Society, where it was received with very favorable comment. Measurements of the field of vision have great value, on occasions, in the diagnosis of cerebral and cerebellar diseases, and the apparatus devised by Dr. Beach is of distinct value for such a procedure when compared with the old, difficult, and often unsatisfactory examinations made by the uncertain aid of the campimeters of older patterns. Congratulations already received by Dr. Beach are surely worthily given and due.

Necrology.

HIRAM HUNT, JR.

Greenville, 1860-1919.

Hiram Hunt, president of our association in 1903, and for thirty-five years a gifted practitioner of medicine in Maine, died at his home



in Greenville, Tuesday, November 4, 1919, after about a year of illness from chronic Bright's disease.

It is a difficult task to write any brief biography of our late comrade, for his adventures in medical practice were innumerable,

yet by condensing many helpful notes from loving friends we will try to outline for him a friendly miniature.

After stating the fact that he was born in Robbinstown, November 15, 1860, the son of Hiram and Sarah Bonsal Hunt, we note that he was educated in the public schools of his native town, then in the High School at Eastport, was graduated at Kent's Hill Academy, and finally spent a year at Dartmouth, where he proved himself an excellent scholar, as well as a versatile tackle on the eleven, and a sturdy first baseman on the nine.

During portions of these early years he taught school, but was working in Portland when he happened to room with a medical student, began to look into his books on anatomy and medicine, so that soon his one idea was the practice of medicine at every hazard. After attending the regular series of lectures at the Bowdoin Medical School he obtained his degree in 1884, and as he happened at that time to be studying angina pectoris, a case or two of which had come under his notice in the hospital wards, he chose that detonating disease as a theme for his excellent graduating thesis.

Directly after obtaining his diploma he heard of a chance for practice at Monson, but although he went there immediately he found the vacancy already occupied. Whilst still at Monson some physician suggested Greenville. He drove over at once, found a house and an office that very same day, and began his enviable career.

Greenville was then a small village, but it soon began to expand, and Dr. Hunt made it his business from the first, not only to care for the sick who wanted his services, but to study public health. He interested himself deeply in the daily home life of the villagers and workmen, did what he could for healthy homes and took great pleasure in the children, serving for several years as a capable superintendent of schools. As manufactories sprang up he begged that part of the building for the Y. W. C. A. should be set off for a hospital. When that outgrew its accommodations, he interested the management of a large corporation so deeply in his plans for town improvement that the A. L. Dean Hospital, with twenty-five beds, was built and equipped with the proper apparatus. Amongst the novelties obtained was an X-ray machine, which Dr. Hunt soon learned to manage and to interpret its pictures personally, and he found it of great service in the diagnosis of fractures, of which he saw many in his practice and with the results of which he was proud. He also induced the founder of the hospital to build a home for nurses, but, as the giver said in presenting the hospital and the home as a gift to the town: "These buildings are really not so much a gift to Greenville as they are a

public monument to Dr. Hunt, whose persistent appeals to me made them finally possible."

Dr. Hunt was married in Greenville, September 12, 1889, to Miss Mabel Sanders Bigney, daughter of Benjamin Stevens and Lydia Bigney, who became his genial companion and friend, and who now survives him after a happy married life of thirty years together.

Many pages might be written concerning the career of Hiram Hunt. He wrote good papers. Every one of them showed him absorbed in his topic. When he wrote on "Cold Abscesses," he was interested in their cure and he wanted you, as a listener, to be. This essay was so well received that a copy was asked for printing in the West. The letter asking this favor was highly prized by the essayist, and remained one of his most cherished treasures. Another paper on "Pneumonia" seized the salient points of diagnosis and treatment, and sounded them forth clearly to the ear of the audience.

He was deeply absorbed at one time in the question of the survival of life after prolonged submersion, and in an association paper he reported six cases of his own, two only of which came back to life, one after two minutes of submersion, another after six minutes. In each an hour's work was needed to bring back life. In order to prove his point in the latter instance, he reconstructed the whole affair, watch in hand; a dummy man falling over a twenty-foot dam; the alarm; the running for and bringing back a rope; the dropping of it over the dam; the bringing of the rope up again with the unexpected surprise (as actually occurred in the case) of an apparently dead man grabbing the rope for dear life, though totally unconscious; and then the "motoring" back to consciousness. Few physicians have ever constructed a scenario like that for the foundation of a medical paper! When Dr. Hunt noted the time needed to carry it out he could surely claim that he had once brought back to life a person submerged for six minutes at least, by the watch, whilst two many other similar cases were merely guess work.

As a member of our association he was a keen debater, ever ready to start a discussion or to urge it along when speakers lagged. As president he made a genial presiding officer at the meeting, and worked hard in his council meetings with the county societies. His address was a model of what such affairs should be, with its valuable recommendations for the members as well as for public health. His oration, "The Relation of the Physician to the State," as president of the Penobscot County Society in 1908, was keenly listened to.

Dr. Hunt was a good public speaker, and in steady demand for civic affairs at home—Memorial Day and other occasions—as well as

festal meetings of our association. He was also quick at repartee, and few who were present on one occasion now to be mentioned will ever forget it. The toastmaster of the occasion, who had not long before emerged from a suit at law, introduced "our next speaker" about as follows: "We all have our trials and our tribulations in the practice of medicine, but there is no greater tribulation than when a doctor calls on a patient and is met with a chilly reception for carelessly exposing himself in a storm. It is said of one of our members that when rebuked on such an occasion he said, 'Oh, never mind, I had another case near by and I thought I might as well kill two birds with one stone.' 'Not me, for one,' cried the patient, jumping out of bed. I now have the pleasure," added the toastmaster, "of introducing the doctor in question, Dr. Hunt, of Greenville." Dr. Hunt stood up, swept the audience with a glance, smiled at the toastmaster, and said: "Yes, indeed, many of us have just such tribulations, but few of us, thank God, ever have a trial."

He also possessed the gift of story telling, and passed along many of those jokes which slip off of the end of the tongue, but cannot always be caught in the flight of sound for repetition in print. He was once driving a restless horse, which shied at every flying leaf or scrap of paper, and he finally said: "Well, if that horse were only fitted with astigmatic lenses he wouldn't be such a shyder."

In his wide practice he often had long journeys to travel. Once he was crossing the forty miles of ice on frozen Moosehead Lake when his horse stopped. He got out of the sleigh and found open water ahead. He lost horses through such holes more than once, and had many narrow escapes himself. Once again in a heavy snow storm his lantern was blown out, so he gave the reins to the horse, who finally came to a stop, deliberately turned off at right angles, and finally walked on frozen ground. There, with robes and the protection of the pines, they passed the night only to find at daybreak that they had nearly gone together over the dam.

As a surgeon Dr. Hunt was at home with modern methods and demands. He kept himself in trim by often attending post graduate courses, and he never remained long in any place with a hospital without dropping in to see what the surgeons were doing. Amongst the list of operations which he performed may be found strangulated hernia, Cæsarean section, gastric ulcers, ectopic pregnancies and various others of capital rank. Perhaps his most remarkable case was that of a railroad employee, who was pitched off of the top of a car, with the car finally toppling down over him and the embankment, with a dislocated shoulder, compound fracture of both bones

of a leg, two fractured ribs, and plenty of burns and bruises. Yet he not only came out alive, but he lived, as one might say, to keep on making a living as a railroad employee. The company simply couldn't get rid of him as he used to say with a grin at Dr. Hunt.

After years of hard country practice Dr. Hunt began to feel the need of a rest in the winter as preparation for a long summer's work, and buying a place in Florida he spent some months of each winter there in milder climate. The halftone at the head of this notice shows him standing on a pier jutting into the Halifax River, near Daytona, Florida, and its beach, and watching the sea gulls as they aviate with outspread wings.

The winter of 1917-18 opened well with our genial friend, but toward Christmas he had an attack of acute nephritis, another followed in the spring of 1919, and in June, on his way home, he suffered still another, and was obliged to rest in the Massachusetts General Hospital. June saw him in Greenville once more, where he enjoyed the use of his horses and his motor car. Soon he who had done so much for others could do no more, even for himself, and then his friends rallied about him with gifts of game and fish, kind words of encouragement and wishes for recovery. But it was not to be. Looking calmly day by day on approaching farewell to all those things which he loved so much, he fell asleep on the evening of November 3rd, and on the 4th had ceased to live.

It is not often that any society of physicians is called upon to lose an abler man than was Dr. Hiram Hunt, of Greenville, for, as one who knew him well has said to me: "He was one of those men whom God loves now and then to create and then to take back to himself for good."

J. A. S.

CHARLES WESLEY PILLSBURY.

Saco, 1851-1919.

After a long illness supervening upon an operation on the liver, Dr. Pillsbury died at his home December 3, 1919. Although he rather felt from the previous May that he had no chances for living long, he remained optimistic and cheerful to the last, consoled and buoyed up by his deep religious sentiments and aspirations.

He was born in Scarboro, June 30, 1851, a son of Charles and Eunice Whitehouse Pillsbury, was educated at Kent's Hill, and then during intervals of teaching he followed out intermittently his longing for medicine by attending lectures at the Bowdoin Medical School, obtaining his degree in 1881, at the age of thirty, at the Dartmouth

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Medical School. He also studied in the office and followed up the practice of Dr. J. E. L. Kimball, a man at that time famous in Saco medicine. This connection gave him a chance to obtain the office of city physician, and a place on the Board of Health, which he occupied for several years. He was for many years a striking figure in Saco and the surrounding territory, over which he practiced widely in his prime. His aspect was somewhat ministerial, and possibly he unconsciously imitated a ministerial manner from his given name. He earned, and always maintained, the reputation of a painstaking, conservative, and trustworthy family physician, and of a sociable, kind-hearted, sympathetic man, his greatest successes coming from his skillful treatment of pulmonary diseases, as well as from his cheerful and consoling suggestions.

Soon after obtaining his degree, he was married in 1881 to Miss Ella Emerson Farnsworth Miller, of South Lincoln, Mass., who died in 1903. He is now survived by children—daughters and sons, one of whom is a practicing physician in Lowell, Mass.

Dr. Pillsbury was bitterly opposed to cigarette smoking and to tobacco. He wrote for our association a clever and a very well balanced paper concerning this soother of men's minds, in which he laid down its history and its former medicinal uses. In spite of every



(C.H.T.)

possible argument in favor of its utility advanced by its innumerable habitues, he could only come to this wise conclusion; that tobacco is a virulent poison, unfit for any medical uses, and when smoked is a great menace to human life, because its influence upon humanity is totally unappreciated and wonderfully insidious.

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Correspondence.

J. A. SPALDING, M. D.,
Editorial Board Maine Medical Journal,
Portland, Maine.

Dear Dr. Spalding:—The year 1920 began auspiciously for the Portland Medical Club on January 1st with a paper of unusual merit by Dr. H. J. Everett, recounting his experience with the "flu" at camp Zachary Taylor in the fall of 1918.

Diagrammatically, the essayist showed the number of cases of "flu" and pneumonia in camp, their relation to each other in point of time of onset, rapidity of development, and the fatalities resulting from both. Then followed a brief statement concerning the bacteriology of the two diseases. Of particular value, however, to clinicians was his account of the therapy employed, which laid special emphasis on the supreme importance of rest in bed and relegated to second and third places respectively such agents as drugs and vaccines.

The paper was one of extraordinarily practical value and interest, and the pity is that so few members availed themselves of the opportunity to profit by the writer's scientific experience in the treatment of this monster disease that is certain to confront us again sooner or later. Those who absented themselves were distinctly the losers.

The lack of responsibility for the success of these meetings which a large majority of the members manifest will, however, if persisted in, ruin one of Maine's most useful medical organizations. Men with ideas and ability to express them will very properly decline to present papers to audiences of fifteen or twenty. A club membership of one hundred and twelve, with barely a quorum (15) sufficiently interested to attend nine monthly meetings during the year, insults a member by asking him to read. Indeed, all incentive to such effort is already conspicuous by its absence, and, accordingly, it is becoming increasingly more difficult to arrange a program. He who complains that the meetings are not worth while will probably find one reason for the state of things which he so glibly deprecates within himself.

Meetings cannot be had without men, neither can essayists; both are essential.

It is the purpose of the present officers to maintain a high standard of excellence for those who are allowed to read, in which respect a good beginning has been made. To that end they invite suggestions or criticisms; they solicit papers and ask for hearty co-operation from all concerned. Whether the Portland Medical Club shall continue in its hitherto honorable career or sink into innocuous desuetude rests entirely with its members.

If these sentiments meet with the approval of your editorial board, will you oblige me by publishing them in the next issue of the MAINE MEDICAL JOURNAL.

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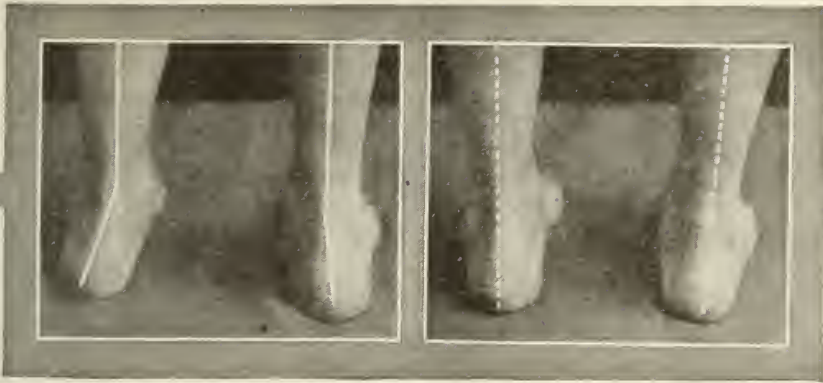
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VOL. X.

FEBRUARY, 1920.

No. 7

* THE CONTROL OF VENEREAL DISEASE IN MAINE.

By DR. H. E. HITCHCOCK,

A. A. Surg. U. S. P. H. S., Augusta, Me.

It may not be safely assumed that the venereal disease control regulations of the State Department of Health are generally known to physicians, therefore while discussing the administration of the law it may be well to recite the law itself. These regulations conform to the requirements of the U. S. Public Health Service and seem to be sufficient for the purpose, although undoubtedly some revision and amendments may be necessary in the near future for their best practical application. Local ordinances in aid of law enforcement are needed and all of the favorable public sentiment that an intelligent appreciation of the wonderful opportunity presented will eventually develop. This paper deals with the laws of this great health problem alone, the several other aspects of the question being omitted to conform with the request of the program committee.

RULE 1

OF THE

RULES AND REGULATIONS OF THE STATE DEPARTMENT OF HEALTH FOR THE CONTROL OF VENEREAL DISEASES.

Section 1 provides that every known venereal disease case shall be reported, at least by number, to the State Department of Health, and

*Read at meeting of Maine Medical Association, at Portland, June, 1919.

is theoretically quarantinable (Rule 7 of the Rules and Regulations relating to the infectious diseases), and reads as follows:

"SECTION 1. NATURE OF REPORT. Any physician, or other person, who makes a diagnosis in, or treats a case of syphilis, gonococcus infection or chancroid, and every superintendent or manager of a hospital, dispensary, or charitable or penal institution in which there is a case of venereal disease, shall report such case immediately in writing to the State Department of Health, giving the case or office number, marital condition, age, sex, color, and occupation of the diseased person, and the stage or date of onset of the disease, and the probable source of infection: the name and address of the diseased person need not be stated except as hereinafter specifically required."

This report is made upon Form V—5 supplied physicians by the State Department of Health, and conveys certain data of a case of venereal disease designated by a number printed in red upon the card for convenience in filing, and is mailed by the physician to the State Department of Health.

Section 2 provides that the full name and residence shall be reported to the local board of health and the State Department of the venereally diseased person who becomes a quarantinable case in fact by disobeying directions and constituting himself a public menace. The text reads:

"SECTION 2. CONDITIONS UNDER WHICH THE NAME OF A PATIENT IS TO BE REPORTED. It shall be the duty of any physician to whom a person having venereal disease or reasonably suspected of having venereal disease, applies for diagnosis or treatment, to report to the local health officer and to the State Department of Health at once, the name and address of such person if he or she shall fail to employ another physician within 10 days of the day when last ordered to reappear by the physician first consulted. The report shall be mailed in a sealed envelope.

"It shall be the duty of any physician to whom a person having venereal disease or who should be suspected of having venereal disease, applies for diagnosis or treatment, to inquire of and ascertain from him or her whether he or she has been to a physician, and if so to ascertain the name and address of the physician last consulted and thereupon notify him of the patient's change of advisers.

"It shall be the duty of the patient to furnish this information, and any refusal to do so, or a falsification of the name or address of the physician shall be deemed a violation of these regulations."

This report is made upon Form V—2 and informs the local health

officer and the State Department of Health that a vicious or an irresponsible person infected with venereal disease is at large and not under proper treatment or control and is therefore a public menace. Thereupon the responsible officer at the State Department of Health directs the local health officer to quarantine such case until non-communicable or until he or she complies with the law, his or her signature to a certain contract being the condition of their release from quarantine. This printed agreement is known as Form V—6 and is supplied to the health officers only. The regulation (Rule 5) reads as follows:

"SECTION 4. SIGNED STATEMENT. Any person not cured before release from quarantine shall be required to sign the following statement after the blank spaces have been filled to the satisfaction of the local health officer, and the health officer shall inform all persons who are about to be released from quarantine for venereal disease, in case they are not cured, what further treatment should be taken to complete their cure. 'I residing at hereby acknowledge the fact that I am at this time infected with and agree to place myself under the medical care of within hours; and that I will remain under treatment of said physician or clinic until released by the health officer or until my case is transferred with the approval of said health officer to another regularly licensed physician or an approved clinic.

"'I hereby further agree to report to the health officer within 4 days after beginning treatment as above agreed and will bring with me a statement from the above physician or clinic of the medical treatment applied in my case, and thereafter will report as often as may be demanded of me by the health officer. I also agree that I will take all precautions recommended by the health officer to prevent the spread of the above diseases to other persons, and that I will not perform any act which would expose other persons to the above disease. I agree until finally released by the health officer to notify him of any change of address and to obtain his consent before moving my abode outside of his jurisdiction.'"

(Dated and signed.)

All persons signing the above agreement shall observe its provisions, and any failure to do so shall be a violation of these regulations. All such agreements shall be filed with the health officer, inaccessible to the public.

Section 3 provides that anybody aware that another person is in danger of becoming infected with venereal disease shall warn such person; also that the source of danger shall be reported to the local

board of health and to the State Department of Health, and reads as follows:

"SECTION 3. REPORTS ON SUSPECTED SOURCES OF INFECTION. If another person knows or has good reason to suspect that a person having syphilis, gonococcus infection or chancroid is so conducting herself or himself as to expose other persons to infection, or is about to so conduct himself or herself, he shall notify the local health officer and the State Department of Health of the name and address of such diseased person and the essential facts in the case. Any person aware that another person is about to expose himself or herself to venereal infection shall warn such person of the danger or report the circumstances to the local health officer, or both."

Section 4 provides that the State Department of Health, when informed, will in turn notify the local health board involved, of the danger; who it is and where the person lives; also assures secrecy on the part of the department as follows:

"SECTION 4. REPORT BY THE STATE DEPARTMENT OF HEALTH. Upon receipt of a report giving name and address of a person having syphilis, gonococcus infection or chancroid, the State Department of Health will report name and address of the person to the local health officer of the city or town of the patient's last known residence as a person having a disease dangerous to the public health and presumably not under proper medical advice and care sufficient to protect others from infection. The State Department of Health shall not divulge the name of the physician making such report and all information and reports concerning persons infected with venereal disease shall be inaccessible to the public, except in so far as publicity may attend the performance of the duties imposed by these regulations and by the laws of the state."

Form V—2 is used to warn the local health officer in this case and requests him to report to the State Department of Health the person whose name is sent him as quarantined—By a physician's case number (evidence that a physician has charge of the case); discharged cured, or beyond the jurisdiction of that local board of health, and if so, any later address known.

Section 5 makes the local health board responsible for the enforcement of health laws within its jurisdiction, as follows:

"SECTION 5. DUTY OF THE LOCAL BOARD OF HEALTH. The local board of health shall enforce the rules and regulations as herein provided and report promptly to the county attorney and the State Depart-

ment of Health any physician or other person liable and failing to report venereal disease as required."

Section 6 provides that the patient shall be adequately instructed by his physician.

"SECTION 6. DUTY OF PHYSICIANS. It shall be the duty of every physician and of every other person who examines or treats a person having syphilis, gonococcus infection or chancroid, not only to report the case as herein provided but also to instruct the patient in measures for preventing the spread of venereal disease and to inform him of the necessity for treatment until cured and to hand him a copy of the circular of information obtainable for this purpose from the State Department of Health."

Any druggist who undertakes to evade the law should have this section in mind. Form V—3, a buff-colored card of vest pocket size, serially numbered to correspond with the number of the report of the case sent in by the physician, with a notice to the patient printed in red charging him to remember his number. This is a card of information and directions to the patient to save the physician time in verbally instructing the patient as the law requires, also for the purpose of frequent reference by the patient and a memo. of his number for the information of any other physician to whom he may go.

The physician should ask such a patient for his number or card at his first visit, and at this time, if the patient has a number or has been treated by a physician, Form V—4 should be filled out and mailed to the physician whom this patient has left to save the patient the annoyance of being quarantined upon notice being received by the State Department of Health that such patient has not returned to his first physician and is not under treatment.

RULE 2.

Section 1 provides that no person arrested under certain circumstances or held in restraint shall be released until examined for venereal disease. Section 1 of Rule 2 reads as follows:

"SECTION 1. PHYSICAL EXAMINATIONS REQUIRED. It shall be the duty of every superintendent, manager or physician of any state, county, municipal or correctional institution, the warden of the State Prison, the superintendent of all prison camps and hospitals, and the sheriff or other keeper of any jail or other penal institution to cause a thorough physical examination as specified by the State Department of Health to be made of each inmate in their respective institutions committed for any term. In conducting the examination special attention

shall be given to determining the presence or absence of communicable diseases, particularly syphilis, gonococcus infection or chancroid, and said examination shall be made by a competent physician satisfactory to the State Department of Health; furthermore, any person apprehended by police authority under conditions leading to suspicion of venereal infection shall not be released or admitted to bail until such an examination shall have been made. The superintendents of all state-aided institutions shall require such an examination of all inmates for whom state aid is given. It shall be the duty of the State Department of Health to promulgate specifications governing the manner and time of the examinations hereby required, to prescribe the medical records to be kept for the guidance of the State Department of Health and to require such laboratory or other diagnostic aids to be used as in its judgment are expedient. It may be obvious that upon such an examination revealing venereal disease the case is turned over to the health officer for quarantine and treatment, unless otherwise controlled.

Section 2 provides that all legally committed persons infected with venereal disease and contagious at the expiration of their term of commitment shall at once be quarantined and treated until their disease is not communicable. Section 129, Chapter 301 of the Revised Statutes of 1917, reads in part:

"If the sentence or term of commitment of an inmate to any such state, county or municipal, charitable or correctional institution expires before such disease is cured, or if in the opinion of the attending physician of the institution or of such physician as the authorities thereof may consult, his discharge would be dangerous to the public health, he shall be continued under such medical treatment, care and custody until in the opinion of such physician his discharge will not endanger the public health."

"SECTION 3. That no discrimination shall be made against the reception and treatment of venereal disease cases in any general hospital supported in part or in whole by municipal, county or state aid."

Incidentally, the requirement of Section 125, Chapter 301, Laws of 1917 of the Revised Statutes, that the person in charge of an institution shall report venereal disease to the State Department of Health, does not relieve the physician treating or having diagnosed the case from his obligation.

"SECTION 4. Any officer named in Rule 2, who neglects or refuses to comply with the provisions of this regulation, or who violates any rule or regulation of the State Department of Health, made under authority hereof, shall be deemed guilty of violating these regulations."

RULE 3.

Section 1 provides for the diligent investigation of venereal disease cases and their source, and authority to examine suspects; also includes as suspects certain persons, such as prostitutes, etc., and reads as follows:

"SECTION 1. All city, county and other local health officers shall use every available means to ascertain the existence of and to investigate all cases of syphilis, gonococcus infection and chancroid within their several territorial jurisdictions, and to ascertain the sources of such infections. Local health officers are hereby empowered and directed to make such examinations of persons reasonably suspected of having syphilis, gonococcus infection or chancroid, as may be necessary for carrying out these regulations. Owing to the prevalence of such diseases among those given to immoral and indiscriminate sexual intercourse, and persons associated with them, all such persons are to be considered within the above class."

RULE 4.

Section 1 provides that to spread venereal disease is unlawful, and for the suppression of prostitution as a health measure. The text of the regulation reads:

"SECTION 1. EXPOSURE TO DISEASE AND SOURCES OF INFECTION. It shall be a violation of these regulations for any infected person knowingly to expose another person to infection with any of the said venereal diseases or for any person to perform an act which exposes another person to infection with venereal disease; prostitution is hereby declared to be a prolific source of syphilis, gonococcus infection and chancroid, and the repression of prostitution is declared to be a public health measure; all local and state health officers are therefore directed to co-operate with the proper officials whose duty it is to enforce laws directed against prostitution and otherwise to use every proper means for the repression of prostitution."

"SECTION 2. DISEASE IN MINORS. It shall be the duty of parents or guardians of minors who have acquired venereal disease, when notified, to be legally responsible for the compliance of such minors with the requirements of these regulations."

"SECTION 3. GIVING CERTIFICATES OF FREEDOM FROM VENEREAL DISEASE PROHIBITED. Physicians, health officers and all other persons are prohibited from issuing certificates of freedom from venereal disease, provided this rule shall not prevent the issuance of necessary statements of freedom from infectious diseases written in such form and

given under such safeguards that their use in solicitation for sexual intercourse would be impossible."

RULE 5.

The authorization of quarantine is necessary to enable the health officer to carry out the provisions of the law and to secure the co-operation of the venereally infected.

"SECTION 1. QUARANTINE AUTHORIZED. Local health officers are authorized and directed to quarantine persons who have or are reasonably suspected of having, syphilis, gonococcus infection or chancroid, whenever in the opinion of said local health authority, state commissioner of health or his agent, quarantine is necessary for the protection of the public health."

Section 2 provides for the responsibility for, and limits of quarantine.

"SECTION 2. LIMITS OF QUARANTINE. In establishing quarantine, the health officer shall designate and define the limit of the area in which the person known to have, or reasonably suspected of having venereal disease, and the immediate attendant are to be quarantined, and no person other than the attending physician shall enter or leave the area of quarantine without the permission of the local health authority."

It may seem undesirable to force an examination in a given suspected case, but quarantine can be imposed until the person elects the examination rather than endure quarantine.

"SECTION 3. No one but the local health officer shall terminate said quarantine and this shall not be done until the diseased person has become non-infectious, as determined by the local board of health or its authorized deputy through the clinical examination and all necessary laboratory tests, or until permission so to do by the State Commissioner of Health, or his agent, or until a written statement as appears in Section 4 of Rule 5, and previously described under the title of a Statement of Agreement, is obtained from the diseased person."

Section 5 provides for the placarding of premises in exceptional instances.

"SECTION 5. PROTECTION OF THE PUBLIC WHERE REGULATIONS ARE VIOLATED. In case a venereally diseased person conducts himself or herself in violation of these regulations and in the opinion of the State Department of Health has become a menace to others, a warning satisfactory to the State Department of Health to those disposed to enter the premises, shall be placed at each entrance to the building

harboring such person, unless said person can be moved promptly to a hospital or other place where isolation and treatment can be carried out."

RULE 6.

Rule 6 provides against incompetent treatment of the venereally diseased and reads as follows: "No druggist or other person not a physician licensed under the laws of this state shall give, sell, prescribe or recommend to any person any drugs, medicines or other substances to be used for the cure or alleviation of syphilis, gonococcus infection or chancroid, or shall compound any drugs or medicines for said purposes from any written or printed formula or order not intended for the person for whom the drugs or medicines are compounded, except on prescription bearing date written, name of patient and signed by a physician licensed under the laws of this state."

In addition to the forms mentioned to facilitate the reporting and control of venereal disease, Form V—7 may be used by the physician to secure evidence that the patient is aware of his or her condition and that he or she has agreed to obey the physician and is informed of the requirements of the law in the case. The physician files this for his own protection, convenience and information. Form V—8 is for the discharge or transfer of a venereal disease case which places the physician on record as having completed his undertaking in a given case and finally canceled his obligation to patient and state. This also secures control of the patient and proper protection of the public.

Finally, the federal regulations for interstate travel of venereally infected persons provides:

"1. Any person, infected with syphilis, gonorrhea, or chancroid, who wishes to engage in interstate travel, must first obtain a permit in writing from the local health officer under whose jurisdiction he resides. This permit shall state that, in the opinion of the health officer, such travel is not dangerous to the public health."

"2. Any person, infected with syphilis, gonorrhea, or chancroid, who wishes to change his residence from one state to another, must first obtain his release, in writing, from the local health officer. He shall inform the local health officer as to the place where he intends to reside and shall agree, in writing, to report in person to the proper health officer within one week after arrival at his new residence.

"It shall be the duty of the health officer who issues the release to promptly notify the health officer under whose jurisdiction the infected person is to enter, of its issue. This release shall contain the name and address of the infected person.

"The receiving health officer shall, in turn, report the arrival of the infected person to the health officer who issued his release and notify the State health officer of his state that a person infected with venereal disease has entered his jurisdiction."

"3. Any person, infected with syphilis, gonorrhea, or chancroid, who wishes to engage in interstate travel or change his residence, shall agree to continue treatment, under the direction of a reputable physician, until the health officer shall have certified that he is no longer infectious. A certificate of non-infection shall not be issued until the health officer, or his accredited representative, shall have complied with the State Board of Health requirements for release of venereally infected persons."

Rule 22 of the Immigration Laws of 1917 provides for arrest and deportation on warrant, of any alien, under 10 paragraphs defining or involving immorality or prostitution, the nearest immigration officer having jurisdiction.

Chapter 112 of the Public Laws of Maine, 1919, is an act defining prostitution, lewdness and assignation and providing punishment therefor. This act took effect March 21, 1919.

Clinics for the free treatment of those unable to pay have been organized in accordance with the specifications of the United States Public Health Service and are receiving arsphenamine free of charge, at Portland, Bath, Augusta, Calais, Bangor and Waterville.

Other clinics in process of organization and about to be organized at Sanford, Milo, Rockland and Lewiston.

In the direction of Education and Publicity, the following named towns have been shown the film "Fit to Fight" preceded by a lecture upon the venereal diseases: Sanford, Springvale, Portland, Fort McKinley, Bowdoin College, Bath, Rockland, Calais, Belfast, Machias, Bangor, Houlton, Fort Fairfield, Presque Isle, Caribou, Ashland, Milo, Dover, Waterville, Augusta, Lewiston, Farmington, Strong, South Paris and Rumford.

STATUS OF VENEREAL DISEASE REPORTING, MAY 31, 1919.

STATE DEPARTMENT OF HEALTH, AUGUSTA, MAINE.

Number physicians pledged to report venereal disease	389
Physicians not pledged but reporting	80
Physicians co-operating by report or pledge	469

Physicians who are pledged and have reported	74
Physicians who are NOT pledged and have reported	80
Total number physicians who have reported	154
Physicians pledged and reporting in the 61 towns from which reports have been received to date	74
Physicians pledged and NOT reporting in the 61 towns	156
Total number physicians in the 61 towns pledged	230
Number towns in which physicians have signed pledge	179
Towns in which physicians have signed pledge and are reporting	54
Towns in which physicians have signed pledge and are NOT reporting	125
Number cities, towns and plantations in Maine	520
Towns in which physicians are pledged	179
Towns in which physicians are NOT pledged but are reporting	7
Towns in which physicians have responded	186
Towns from which there has been no response	334
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Cases gonorrhea reported by number	560
Cases syphilis reported by number	373
Total reports by number received to May 31, 1919	936
Cases gonorrhea reported by name	114
Cases syphilis reported by name	56
Total reports by name received to May 31, 1919	170
Grand Total—Reports by name and number to May 31	1,106

THE PRESIDENT: The discussion of this paper will be opened by Dr. Bristol.

DR. BRISTOL: Mr. President and Members of the Society: I expect my reaction to that paper will be very similar to yours. The most uninteresting reading in the world is to take the statutes of the State of Maine on a subject and read it through, so do not feel especially disappointed because this paper has not been of any great interest to you from the standpoint of stirring your enthusiasm. There are certain points in those rules and regulations that will appeal to the practicing physician; there are other points in those rules and regulations that will be of interest to those who have the law enforcement side of this big problem; there are still other points in the rules and regulations that will be of special interest to the health officers, points having to do with quarantine and so on, so that we cannot, of course, expect that all of these rules and regulations will be of wonderful interest to every member of the medical profession, but we do believe it of value to present them in whole at least once, and every member here cannot say from now on that he at least has not heard these rules and regulations read.

I have only been in the State for two years, but I believe I am correct in saying that your Association has had a committee on venereal diseases for some years, the chairman of which has been Dr. Whittier, working towards the end of an adequate control of venereal diseases in the State of Maine, and I am very

glad to say that I believe that the work of that committee as been very largely instrumental in our being able to have these rules and regulations passed, and apparently to have them approved, not only by the Governor and Council, and the Legislature, but by the people as a whole. The most of the objections to the rules and regulations for the control of venereal disease have come from the standpoint of individual physicians, and in most instances the objections have been founded upon some misunderstanding in regard to those rules and regulations, and the only thing I want to point out in this very brief discussion is that, in the first place, we are simply aiming at the adequate control of a venereal disease case by seeing that it is rendered non-infectious or non-contagious, and we believe the way to do that is to get that person under the qualified physician. If that patient is a law-abiding citizen and is willing to take the treatment, that is the end of it—the doctor reports the case by number and that is the end of it. He simply has to do nothing more in regard to the matter so long as that patient is under his care and taking treatment until he is cured. This long list of rules and regulations is largely for the unruly case of venereal disease, the case that we need to get after, the case that leaves the physician, the case that refuses to go to a physician. Also the rules and regulations help greatly in the enforcement of our laws regarding prostitution and other sources of venereal disease. I see two or three in the audience that I believe you will be specially glad to hear from. We want, of course, to hear the expression of opinion of the practicing physician, but, after all, this problem as a public health problem comes home more to the health officer, and I hope that Dr. Tetreau, your health officer here in Portland, will discuss this problem from the standpoint, perhaps, of how the thing is working out here in Portland, the largest city in the State. Furthermore, I see Miss Briscoe and Mr. Jameson in the audience, and they are chiefly interested in the law enforcement side of this work; and may I say that the United States Government is back of this program and expects to see the thing through so long as the rules and regulations exist in this State. They are back of it with their law-enforcement agency, not with the idea of doing any harm, or anything of that sort, to the person who is really an innocent person so far as the public is concerned, but simply to see to it that the lawless people who are spreading venereal disease about the communities of the State are taken in hand, as they should be. For that reason I think we ought to hear something about how this set of rules and regulations is really helping those who are interested in the law enforcement regarding prostitution, regarding the rounding up of what might be called the criminal classes, and regarding those who are really not living up to the rules and regulations.

I am happy to say that we have been receiving the best of co-operation, I believe, from the medical profession of the State. (Applause).

THE PRESIDENT: The subject is open for general discussion.

DR. PHILLIPS, of Bar Harbor: Mr. President and Gentlemen: I may have to ask the indulgence of this house for going over my time two or three minutes. If not agreeable, please call me to order at the expiration of the five minutes. I think I would like to have about eight minutes to make myself clear.

It perhaps may not be out of place for me to say that nine years ago I read a paper before this Association on prevention of venereal diseases, and asked that a committee be appointed. The Chair, with excellent wisdom, made Dr. Whittier its chairman—efficient, bold, with enthusiasm unquestioned. My next reaching out along this line was caused by my friend, Dr Holt, of this city, who

read a paper before our county society some four or five years ago. He asked me if I would take hold of the matter of eugenics if he would, and I answered, "Yes, assuredly." It started me on the road of planning. One thing appealed to me strongly. First, the never-failing prejudice against innovations in the Legislature, especially among some, against the proposals of the medical profession—bitter, never-failing, stubborn, sometimes full of unreasoning malice. This led to the conclusion that to procure any new legislation of a medical character, a champion of such should be a member of the House or Senate. I am now stronger than ever in that opinion. If we are to have strong measures taken, measures that will be of use, we need to elect, whenever possible, to the Legislature of this State physicians whose avowed object shall be such legislation, and I say "avowed object" advisedly. It is, I believe, the first strong move devoutly to be sought for, and I believe, also, the time has come to call a spade a spade. The prudery, the false camouflage, entered into by everybody, has been and is the millstone hanging about the neck of prevention. Twenty physicians of brains and character, elected with one object in view, to put through a law naming things as they are, recording name, sex and disease exactly as other contagious diseases are named, would cut the number of venereal disease in two in the middle in two years' time. The personal equation must be left out in view of the hundreds of women unsexed from gonorrhea, the blunderers running into thousands—21,000 in one year from this cause in our country—the long years of suffering and ill-health, the broken homes, the blackness of immorality, the loss of self-respect, caused by this disease, and then the deep and abiding curse visited unto the children of the third and fourth generation caused by syphilis. These two hideous octopi reaching their awful, slimy tentacles out into the generations of the future—with this knowledge before us, no prudery, no false consideration of the disease, should stay our hand one jot or one tittle by any means that lie in our power from preventing this entailing curse. We cannot too strongly emphasize the aftermath of venereal diseases. By all the laws of man and God, why should the man who deals out this death-dealing virus to future and innocent generations be protected from exposure when that protection opens the door to hell, even unto the children of the third and fourth generations? Why should the individual be exempt from record when that record may prevent the horrors of damnation along the future trail? I need not recall the slimy history of this presence, the blindness, the spinal diseases, the rotting bones, the imbecility, the moral, mental and physical decadence, the wreckage, the human flotsams, the broken hearts, the throttled self-respect, the murdered happiness, the unsexed women, the shame and shadow and disgrace of it all, and the responsible man or woman the cause of it, and nine times in ten it never would have been but for the puerile prudery that forbids the recording of his name. It is the great remedy in my judgment for the healing of the nations, the great key of prevention. It is the knife that will cut out the sore. I have said before what I say now, that I have no faith in medical ethics that cover crime or worse than crime, that will not betray the victim of sin, but will betray the babe at its mother's breast; that will not betray the villain with his drawn dagger, but folds his robes of self-righteousness about him while the victims fill their untimely graves; that will not betray Judas, but will betray his Lord and Master."

(At this point an extension of time was given Dr. Phillips.)

A man in high station in the church said to me when I offered a bill in the

last House against marriage of syphilitics, "I hope nothing will be done by you that will in any way tend to expose a diseased patient." My God, why not? Shall we see a dozen children, men and women, go to Hades rather than to expose the cause and save them? Such a man, be he bishop or priest, physician or layman, is a menace, an enemy of the human race, for which no judgment is too swift or too sure. Let us have one rule to save life for all contagious diseases, and by so doing, and only by so doing, shall we throttle this menace to the human race. King David's honesty commends itself to all: "My lovers and my friends stand aloof from my sore; and my kinsmen stand afar off For I will declare mine iniquity; I will be sorry for my sin."

In this matter of prevention of diseases, allied as they are to the breeding of men, the neglect has been shamless, almost criminal. Men who handle horses, who care for cattle and sheep, even those who breed poultry and dogs, vie with one another in most careful breeding. All care and pains are taken that every generation shall be better in every physical and mental quality than in the past. Prodigious has been the gain, a gain to be proud of. But man alone is left to take his chance; no hand is raised, no effort made to stay his downward course or prevent his miserable mating; blood and brain and brawn full of tendencies to disease—insanity, venereal diseases, imbeciles, cancer, tuberculosis—all thrown into the melting pot of marriage at the will of the parties concerned, and that because of an emotion born oftentimes of lust that dies or shifts to another in the course of time. All diseases, however foul, are left in his path; every animal but man bred with utmost care. It is a grievous and heinous fault. Who is responsible? What men or profession must shoulder the burden of this neglect? What other than our own profession, with all the readiness that physicians give of their time and brains, with all their self-sacrifice, their willingness to do for humanity. We can only plead guilty to this indictment. Is it not time our voice was heard in protest and that we organized war against this brutal evil? It will seem utterly strange when accomplished that it was not done before. As we wonder now why human slavery existed till Lincoln's proclamation, or a hundred reforms changing the destiny of the race, so we shall wonder why this crime against humanity, this non-interference with the breeding of offspring, has been permitted so long. Let our profession be the pioneers that shall accomplish this salvation of the human race, and may our State, whose proud motto still stands serene and strong, be the first to open this path of abiding splendor to the race builded in the likeness and image of God. (Applause.)

THE PRESIDENT: The paper is open to general discussion. There seems to have been a general lack of understanding about the requirements of this law. Now is the time to ask questions if you wish.

DR. JOHN STURGIS: Mr. President, I was asked to start something. I will do it in a friendly way to bring out possibly a point that may be of interest to you; at least it is of interest to myself. There was a young woman reported as being infected. She says she has never had any evidence of infection so far as she knows, personally. Some doctor reported her to the factory where she was employed, and the proprietor told her, "We don't want you here any more." She said, "Why? Haven't I done my work satisfactorily?" "Yes." "Any fault to find?" "No." "Why are you turning me off so that I cannot earn my livelihood?" "Some doctor has reported that you are infected." She put up a little protest and said, "I don't like it, and I don't want to stand for it. That is why they turned me off, then, at the other place." "The other place where you left

sent that word to us. We have just heard of it, and we have got to tell you that we don't want you." The proprietor said, "There is only one way to keep you and that is for you to be examined by a physician. Will you do it?" She said, "Yes, I will, by any physician that you may name." The proprietor of that factory named John Sturgis, Auburn, Maine, and they made arrangements for me to examine her. I examined her, and by the use of the microscope confirmed gonorrhea. Now that was done just a few days ago. As I understand I am ahead of the law, which does not go into effect, as I read it, until July 1st. Now she does not come to me for treatment. Have I got to report her case to the Board of Health?

Now, the next thing that comes up along this line—what is my attitude, my standing, before the law of this State, the law of our country? The other fellow is out of it in a way; I am the one who confirmed the diagnosis. Now if that girl cannot get a chance to earn her living, who is to blame? Can she sue me for a breach of our etiquette in reporting her to her people, who say that she cannot work for them? If she sues me, who is going to uphold me? I am bringing this up and I hear doctors talk of it outside as I am around in consultation. Is the State Public Health Service going to support me in any suit brought by that woman? I am bringing up a definite case, not supposition, because I have been right through it in less than a week. Must I report her? I am not her attending physician; I am just a diagnostician in the controversy. In this particular case I have reported her to her people, with her consent, confirming the diagnosis. But suppose she turns; who will uphold me? Will the Public Health Service of the State of Maine, or the United States, back up John Sturgis in doing what he thinks is right? If John Sturgis does not report, then the Public Health Service is going to jump on him. Can you tell where he will get off? Now we have got to think of it; there are two sides. When you know that of the peoples of the world possibly 75 per cent. have been or will become infected at sometime during their lives with specific disease, are you going to report three out of four people you meet on the street? That is what it means—75 per cent., gentlemen! It is a big subject. I wish it could be controlled. I do not know how to control such a subject. I thank you. (Applause.)

DR. HITCHCOCK: Mr. President, in the first place, to refer to the rights of the individual as paramount at the expense of the many is absurd. Certainly, the welfare of the many is of paramount interest to the community as a whole. Every one of us has a duty to the community, to the public. Any individual who undertakes or finds himself either in conflict with the law or constituting a menace to the many, is to be controlled, according to a decision of the Attorney-General of the United States—I cannot quote the case. I have that in correspondence. When it comes to a question of liability of the physician, it seems to me that this case is parallel to that of anybody who does as the law requires, but who may be sued, nevertheless, for having complied with the law. I may say that those suits do not come to a head, or have not in the past, to my knowledge. There is liable to be considerable protest and sympathy with the individual, but when that individual has talked the matter over, as he is pretty apt to do before taking action, he becomes aware that he is only one; that he is in a community of many; that he is in a disadvantageous position when it comes to any expense of his own liberty or right at the expense of the community at large. Shall the physician be defended by the United States Public Health Service or by the State Health Department? Why, no, I do not know why he should,

beyond testifying that he has complied with the law or something to that effect. It does seem to me, however, that his defense is better when he has complied with the law, when the law is perfectly clear and he has done nothing but comply with it.

Now, as to the rather extreme question, it seems to me, whether you shall report everybody under the sun, I do not think that concerns us very much. Shall you report everybody that you suspect may be dishonest? If you find a person obviously cheating, or guilty of dishonesty, if you have evidence, it may be a proper thing to take the case up and take action. We do not expect to exterminate venereal disease or prostitutes or revolutions in the world; but we do expect to reduce venereal disease and to control prostitutes. I do not know that I have answered all of Dr. Sturgis' questions.

DR. STURGIS: What about my being called in consultation and confirming the diagnosis? Have I got to report that as well?

DR. HITCHCOCK: I think he should report any case that comes to his knowledge in his professional work. Where is the harm? A case under the control of a physician—no name, no residence. He in no way discloses the identity of that person. He merely acquaints us as a department with the fact that a case is known and is under treatment. No harm done! It takes but a few minutes to make out that report, that's all. He in no way lays himself liable that I can see. I do not see the inconvenience of it.

THE PRESIDENT: Is there any further discussion?

DR. CONNELLAN, of Portland: Mr. President, I am the jail physician of Cumberland County. Since December 11th we have had 56 women examined, and of those 56—26 had syphilis and 30 gonorrhea. We have given them all the Salvarsan treatment and the gonocci treatment, and today we have only one case left. So we have accomplished that much under the provisions of the law since December 11th of last year.

DR. DENNETT, of Massachusetts: Mr. President, I would like to know, if these cases are reported by number, how it was that this woman was known in the two houses where she was employed. It was said that her employers would not retain her any longer because she was infected. It seems as though someone must have leaked somewhere. In regard to reporting, it seems to me if a case is reported once, that is sufficient. If a man is called in consultation to make a diagnosis, and he should tell the physician who had charge of that case, there is no need of reporting it twice. I would like to know how it was that this woman, whose name was supposed to be kept secret, should be known in the two houses. If a diagnosis had been made, she should have been under treatment, or under quarantine, if I interpret the law right as given so admirably by Dr Hitchcock, so I would like to know where the leak occurred. If under proper treatment or under proper quarantine, she certainly would not have been a menace to the house where she was working

DR. STURGIS: I do not know, and neither does the patient know, how the leak came about.

THE PRESIDENT: Originally, two persons knew it, the attending physician and the patient.

DR. STURGIS: The patient denies that she knew she had the disease, and she

denies that she was ever told that she had the disease until she was told by the people who employed her that she was out for that reason.

DR. DOBSON: Didn't she infect somebody?

DR. STURGIS: She told me this: "I never had any reason to suspect that I was a carrier of disease." Those were her exact words.

DR. DOBSON: Did she infect somebody?

DR. STURGIS: I don't know. She denied that she ever had anything to do with any man in Lewiston or Auburn. I asked her that very question, and she denied having anything to do with any man in Lewiston or Auburn. She said, "No man knows anything about me." This definite case brings to my mind what may be quite a menace to all of us. She is a menace, we grant that from what we found out, and someone has caused her a great deal of trouble. I will say one thing, that the people who have employed her have told me that, if she will come under treatment and be reasonably cleared of that disease, they will put her back to work. They are acting the part of men toward those in their employ.

DR. HITCHCOCK: Mr. President, it occurs to me to say that there is no way of guaranteeing that the condition of any individual will not become known; no possibility of it. The only guaranty we can offer is that we will not tell, that the knowledge that comes to us will not be made known outside of our own department. We have these reports daily in increasing numbers, covering the whole State, as well as from Boston and other places outside the State. The girl who has charge of the correspondence and the immediate filing has seen them until she has no interest in who has gonorrhea and who has syphilis. These things are spoken of as freely as one speaks of getting up in the morning and going about his business; it is an old story with us. There is no disposition on the part of that girl, any more than there is on the part of myself, to discuss the matter. In the first place, she is cautioned that she must not leak, because those who knew about those reports were herself and myself; that in case of any suspicion of leakage, I should know that either she or I were responsible, and that one of us would quit the job. It is put in just such language. Moreover, this whole question is larger than that of any community or group. It is national. I will admit frankly that the present handling of it must of necessity be more or less crude as compared with what we hope will obtain in the future. When compared with the magnitude of this question, these trifling side issues seem rather small, but they are in the direction of the improvement that will surely come about through free discussion of this matter, free airing of our objections, and moreover, a generous contribution of constructive criticism.

THE PROFESSIONAL MAN'S INCOME TAX.

Figuring Income Tax is an easy job for the professional man. By education and training he is accustomed to drawing up statements. He has records of transactions involving income, and keeps well in touch with his expenditures.

Just what he is allowed to deduct as professional expense, in figuring his net income, is what he wants to know each year as the tax season arrives. Therefore, a review of the items in general is given in this article.

RETURNS FOR 1919.

The present Income Tax law requires that returns for 1919 be filed on or before March 15, 1920, at the office of the Collector of Internal Revenue for the district in which the taxpayer lives. At least one quarter of the tax due must accompany the return.

An unmarried person must file a return if his or her net income was \$1000. or over; and a married person living with wife (or husband) must file if their joint income was \$2000. or over. A widow or widower, or a married person living apart from wife (or husband) is classed as a single person.

The requirement to file a Federal Income Tax return is not contingent upon there being a tax due.

Form 1040A is used for net income of not more than \$5000.; Form 1040 for net income over \$5000. Instructions and a working sheet accompany each return form.

Every firm of professional men operating as a corporation must make an annual return of net income on Form 1120; if operating as a partnership, a return on Form 1065 must be filed.

GROSS INCOME.

An individual's gross income from a profession includes all compensation for his services.

Where services are paid for with something other than money, the fair market value of the thing taken in payment is the amount to be included as income. If the services were rendered at a stipulated price, in the absence of evidence to the contrary such price will be presumed to be the fair value of the compensation received.

In the case of a salary received, this should be shown separately, in Block B, of the return. Many professional men and women—lawyers, medical examiners, teachers, accountants, etc.—are officers or employees of a State, or a political subdivision of a State, such as city, town or county. Their salaries or wages as such officers or employees is exempt from the Federal Income Tax. The exemption also applies

to fees received by notaries public commissioned by States, also the commissions of receivers appointed by State courts.

As to fees for services to clients, patients, etc., these should be included in the gross income for the taxable year in which received, unless they are included when they accrue to him in accordance with an approved method of accounting followed by him.

CASH BASIS.

A professional man may make his return on the basis of cash intake and actual expenditures for the year. It should be noted here that a taxpayer is deemed to have received income which has been credited to or set apart for him without restriction.

ACCRUAL BASIS.

A more exact and equitable method of figuring net income is on the "accrual basis." This means a computation on the basis of income earned and expenses incurred, whether paid or not, that actually pertain to the taxable year, excluding income earned and expenses incurred in previous or succeeding years. A professional man who keeps books of account should make returns by this method, if his accounting method is one generally employed and shows a correct net income.

DEDUCTIONS.

A professional man may claim as deductions the cost of supplies used by him in the practice of his profession, expenses paid in the operation and repair of an automobile used in making professional calls, dues to professional societies and subscriptions to professional journals, the rent paid for office rooms, the expense of the fuel, light, water, telephone, etc., used in such offices, and the hire of office assistants. Amounts expended for books, furniture and professional instruments and equipment of a permanent character are not allowable as deductions.

In the deductions from gross income, the law specifically bars personal living or family expenses.

In the case of a professional man who has a regular place of business and who rents a residence, but incidentally receives there clients, patients or callers in connection with his professional work, no part of the rent at his home is deductible. If, however, he uses part of the house for his office, such portion of the rent as is properly attributable to such office is deductible.

BAD DEBTS.

The uncollectible bills, of professional men, particularly doctors, dentists and lawyers, have a very important bearing on the net earnings for each year. The principal point in connection with such accounts made in Income Tax procedure is that there can be no allowance for such bad debts in returns figured on the "cash basis." That is, a person who has been making his annual returns on the basis of cash received and actual cash expenditures each year has never shown as income his accounts with patients or clients, and is, therefore, not entitled to take them out of income.

On the other hand, a person who annually figured his gross income on the "accrual basis," that is, included his cash receipts and charges against patients and clients for all of his services performed during each year, is entitled to a deduction for "bad debts" covering such accounts as he ascertained during the year were uncollectible and charged off on his books.

An account merely written down or a debt known to be worthless prior to the beginning of the taxable year is not a proper item for deduction.

WEAR AND TEAR.

A reasonable allowance for the wear and tear and obsolescence of such instruments and equipment, etc., is allowed. The proper allowance is that amount which should be set aside for the taxable year in accordance with a consistent plan by which the total of such amounts for the useful life of the property will suffice, with the salvage or scrap value, at the end of such useful life, to provide in place of the property its cost or its value as of March 1, 1913, if acquired by the taxpayer before that date.

OBsolescence.

When through some new invention, or radical change in methods, or similar circumstance, the usefulness in his profession of some or all of his instruments or other equipment is suddenly terminated, so that he discards such assets permanently from use, he may claim as a loss in that year the difference between the cost (reduced by reasonable adjustment for wear and tear, which it has undergone) and its junk or salvage value. If the apparatus was owned prior to March 1, 1913, its fair market value on that date should be considered, instead of its cost, in figuring obsolescence. This deduction is allowed by law, but the taxpayer must be able to substantiate any claim made on this basis.

PHYSICIANS' AND SURGEONS' EXCHANGE:

Special telephone exchanges, the business of which is to locate physicians and surgeons, are being installed in many cities in this country. The doctor, like the telephone, must be on the job all the time, and his whereabouts must be known by someone. To make such a condition possible, Physicians' and Surgeons' Exchanges are coming into existence and they have a real mission.

The first Physicians' and Surgeons' Exchange was established a dozen years ago in San Francisco. It came into being without premeditation, as a result of the fact that doctors practiced on one side of the bay and lived on the other and couldn't get across conveniently after a certain time at night. They took turns in staying, over a pair at a time, to handle the work of their group at a central location. In time an exchange developed. Los Angeles, San Diego and Chicago soon followed the example of San Francisco. About two years ago Boston started an exchange, which I believe is doing splendid work. Others are located at St. Joseph, Mo.; Tulsa, Okla., and Oklahoma City, Okla.; Des Moines, Ia.; Wichita, Kansas; and St. Louis, Mo. The most recent was that in Oklahoma City, Okla.

The Portland Exchange began the first of the year and numbers among its members our best known Physicians and Surgeons in their profession in Portland. If a man calls his doctor's office or home and gets no reply, he then calls the Exchange and the Exchange lays a barrage of telephone calls about the doctor who is wanted; if it is necessary, it intercepts him on his route; it makes it certain that he must run into a call before many minutes have elapsed, no matter which way he turns. It takes the burden of finding him off the worried household of the patient and it goes about the hunt in a thoroughly systematic way.

The Exchange has the schedule of the doctors who are members. This schedule gives the routine work of the member and the hours he spends in Hospital work or any other form of Relief work which he plans to do. His regular office hours, which are by no means the same with all doctors, the Clubs to which he belongs, etc. This schedule is of course constantly interrupted by urgent calls, but on the whole it is a great help and the Exchange manages in almost every case to find the Doctor somewhere. Each day the members telephone the Exchange any new information which he may care to have them know.

When the Physician wishes to spend the evening away from home, he notifies the Exchange at what theatre, club or residence he may be found and the Exchange transfers his calls to his exact location. If on Sunday or any other time he wishes to take his entire family for an

auto ride, he notifies the Exchange and it is able to tell inquirers when he will be back.

Toll calls will be given special attention. If a Doctor out of the City wishing to locate a particular Doctor in Portland and is unable to do so by calling his office, will tell the Toll operator to try this Exchange, we will bring every possible means into play to locate him for them, or any messages that one wishes to have delivered will be carefully written down and delivered at the earliest opportunity.

We have already done considerable work with Toll Calls and, while the Exchange is for the exclusive use of the members, still we are often asked to locate men who are not members, and while we do not have the schedules of these men, we are nearly always successful in finding them and are always willing to make the effort.

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Editorial Comment.**OPEN HOSPITALS.**

It is a good idea to read medical journals from anywhere, as well as from everywhere, because every one of them contains something suggestive for Maine. We note, for instance, in the *Illinois Medical Journal* for December that the open hospital idea is making steady advances toward universality in this country. The cry is, that the hospitals belong to the county, State, or municipality, as the case may be, and for that reason should be open to the registered physicians of the State. One argument against this is the inefficiency of some registered physicians, and another that the hospital as a corporation would have to stand before the law in case of bad work done by incompetent men. To this it can be replied that any man who can practice successfully as a physician in the homes of his patients can practice with the same success in the wards of any hospital. Then, again, is not actual registration a proof of medical ability? Finally, does a hospital invariably defend suits against members of its staff?

If one hospital can let patients be treated by any registered physician, so can another. The Minturn Hospital has been run for diphtheria and scarlatinal cases for eighteen years and has not even a resident physician, to say nothing of a staff. This is startling news to those of us unfamiliar with such a fact.

Everybody recalls the strife when the Maine General, after much

difficulty, got going, but limited the physicians who could treat patients to a staff. Pennsylvania came very near passing a law that any hospital refusing to permit any registered physician to treat a patient in the wards should thenceforth be cut off from State appropriations. Such a law will come there ere long. Connecticut, as we hear, permits any duly licensed physician to operate on a ward—or private—patient in any hospital in the State. This can also be said for some cities like Detroit and Cincinnati. If we are incorrect, we stand open to proof to the contrary.

A very vital point at issue in this business is that the opening of all hospitals to all registered physicians would put off longer the evil day of health insurance and state-waged physicians, for then the cry for health insurance and communistic treatment would have small foundation for popular support or legislative action.

ANNUAL REGISTRATION OF PHYSICIANS.

We have already mentioned that it is proposed in Illinois to register physicians every year at a cost of \$2.00 or more, on the ground that the State Department of Health wants to keep in yearly touch with all physicians, first, to keep out quacks, and secondly, to send out the government directions and pamphlets for the prevention and spread of the venereal, as well as for drug addiction. Moreover, it is claimed that by an annual registration, doctors can be more readily followed up for neglect in the registration of births.

Nothing of this sort has yet been mentioned in Maine, but we all know what sort of people we are. Somebody sets up a new law in California, for instance, and then, no matter whether it works well or ill, and no matter whether anybody takes the trouble to find out how it works, some other state passes the same kind of legislation, and we are red-taped forever in our struggle for existence. We know of no single way in which such plans as this may be obstructed that can compare with a Board of Organization within the Maine Medical Association, having also in view to present a permanent obstacle to kindred legislation, health insurance, and so on whenever appearing to view.

A law of registration is on a par with that for prohibition, under the provisions of which no person can own an encyclopædia, because it contains somewhere directions how to make light wines and hop beers. Our public libraries are being denuded of volumes of standard cyclopædias in obedience to the present law for prohibition.

As to registration, telephone directories contain the names of all practicing physicians, and so do the records of the Board of Registra-

tion. Either of these could be consulted rather than to compel us to pay an annual fee, to say nothing of a fine of \$10.00 for forgetting to pay it before the day of delinquency set, and be prohibited from earning a living until those in authority see fit to grant us renewal of a registration to practice.

California has just such a law as this, and every physician must register every year before the first day of March. If he does not do so he loses his right to practice until the State Department of Health issues him a permit, and worse than this, his name goes off the lists automatically, and does not go on again until the following year, something which makes a terrible fact to face for all physicians concerned, for he is nowhere as a physician for a year of his life. It is our duty to remember these facts, and if ever yearly registration is proposed, to obstruct it in every possible way.

THE UTERINE INCISION IN THE CAESAREAN SECTION.

Although this operation is not often performed, yet its occurrence in obstetrical practice at any time may excuse a brief annotation concerning the best method of making the uterine incision. We find bearing on this point, a paper and a long discussion held in the North of England Obstetrical Society, in which Kerr opened the discussion, putting forward these reasons against the ordinary longitudinal incision: the cicatrix, he claimed, was invariably starved, because the sutures were used both as hæmostatic agents and coaptors. Coaptation was difficult to get because the sheets of muscle in the uterine wall were irregularly distributed and the uterus was in a state of unrest (normal contraction) and of involution. Finally, blood tended to collect between the surfaces, thus producing bands of fibrous tissue liable to stretch or give way entirely in subsequent pregnancies. He suggested in place of through and through sutures after delivery of the placenta immediate suture in layers, the placenta being left to pass through the cervix, delivery through a low transverse incision in the lower uterine segment, assisted by Trendelenberg position, expression of the child behind the fundus, the cord to be replaced in the uterus and the placenta allowed natural delivery. The only pertinent objection in his mind was possible gravitation of deleterious material toward the fundus of the uterus.

The trend of the discussion was toward confidence in the longitudinal incision. Some sutured with catgut as soon as the child was delivered. Some favored a short longitudinal incision, others a high vertical; some used silk, others catgut; some used through and through,

omitting the mucosa. Generally, the lower segment was condemned, because it was essentially weak.

Many clinical instances were mentioned in favor of the longitudinal incision, to all of which Kerr replied, maintaining his position in favor of the lower transverse incision.

HEALTH BULLETIN NO. 1 FOR 1920.

The latest Bulletin from the State Department of Health for January, 1920, is at hand this day and contains notices concerning "Humanity Bookkeeping," "Venereal Clinics" and "Maine's Maximum Death Rate." From these items we note as salient facts of interest to physicians, that delay in registration of births, concerning which much complaint has been made against attendant physicians, is largely due to the parents failing for several weeks after the birth of a child to provide the infant with a name that can be registered. This seems odd, considering that a good many months of anxious waiting for the infant might give the parents a chance to provide a name for either sex. At all events, we are glad to know that failures to register are not the fault of the physician at all, and likewise pleased that a satisfactory explanation of apparent neglect on the part of the physicians attending births has been offered to the public.

We are gratified that five anti-venereal clinics are already in working order in the State, and doing useful service. We trust that the physicians in attendance are allowed some fair authority to throw out those who are able to pay something for an untold benefit, for already the profession is too largely burdened with free treatment for various afflictions. Finally, we note with astonishment the death record of Maine for 1918, at a total of over fourteen thousand, in comparison with a total of only eleven thousand in about the same population in the previous year. Certainly the word "Appalling" fits well into such a list of deaths, the increased figures being referred by the department, and we believe very properly, to the influenza epidemic of that year alone.

THE EYESIGHT OF MOTOR DRIVERS IN GREAT BRITAIN.

A council of British ophthalmologists recommends something like the following demands for the sight of motor car drivers of all sorts. That before they get any license at all they must show that they can steer around corners, avoid obstacles, and be physically able to drive a car: that if a driver meets with an accident he must be tested to see if due to his sight, and that special eyesight certificates be granted accord-

ing to results obtained after examination by trained ophthalmic surgeons.

A Grade A certificate would show that the owner could drive any sort of a motor vehicle, Grade B could drive anything but a motor bus or trolley car, and Grade C ability to drive a motor car only. Grade A includes, additionally, ability to drive by day or in dimmed light, and a trial trip to be made at night. Vision must be at least 6/9 in one eye and 6/20 in the other. Visual field must be perfect and no manifest strabismus offering itself. Grade B should have the same requirements for vision and undergo a trial at night, for motor cars only. Grade C should be able to drive a motor car on a track or a motor omnibus by day or night, by trial.

Drivers of taxis should be licensed also and should have vision 6/12 in one eye and 6/30 in the other. Owners of all sorts of motor vehicles are urged to employ only men who have been tested as above, and can show a certificate. Temporary certificates may be issued to learners, the holders thereof to be accompanied in their trial trips invariably by a driver licensed as above.

These suggestions meet with the approval of every thinking person, and we may hope that ultimately the public will demand that the sight of both eyes of all drivers, and particularly that fields of vision, shall be carefully tested by a skilled ophthalmic surgeon. Too many motor accidents occur in our country, and a very considerable number of them are most positively due to defective eyesight, to say nothing of loss of perception of form in the fields of vision.

INDICATIONS FOR THE CAESAREAN OPERATION.

Couinaud lays down the indications for this serious operation, and gives, first, vaginal stenosis from cicatricial contraction only. In natural stenosis the fœtus is viable. The operation is demanded with uterine rupture threatening. In rigidity of the cervix remaining stationary the abdominal section is the thing. The operation is not permissible in eclampsia. It may be done with an excessively large fœtus. With obvious fœtal distress the operation is permissible, as also in various presentations, such as with the face, forehead, and shoulder. With complete dystocia, the placenta lying low, this operation can be done. So, too, this is the rule in retro-placental hemorrhage. Finally, in the rare instances of procidence of the cord the Cæsarean section is proper. As the writer of the essay states, it is quite a different matter in doing this operation in a well applaned hospital when compared with the indifferent service to be found in ordinary homes in such emergencies.

FEDERAL AID TO SOLDIERS.

In almost every community in the United States there is a discharged soldier, sailor, marine, or war nurse, suffering from some injury, or ailment, which dates back to service with the fighting forces.

Often this injury or ailment has made it hard or impossible for them to fit in where they did formerly. They are handicapped and need help; not charity, but mental and physical reconstruction. In many cases such people unfortunately keep their troubles to themselves. They are reluctant to seek aid or advice, for fear their friends might consider them weak. Possibly you know such a person.

If you do, encourage him to take his troubles to the Government. The War Risk Insurance Bureau and the United States Public Health Service are especially anxious to get in touch with such individuals. The Public Health Service has set up a chain of reconstruction bases throughout the country for beneficiaries of the War Risk Bureau. These are not Army hospitals, nor is there Army discipline in connection with them, but rather a system of hospitals similar to the general hospital in large cities except that the treatment is free and goes much further than in the ordinary hospital.

Recreation, vocational training and wholesome entertainment are combined with treatment. While men are being bodily rebuilt they have the opportunity of learning some useful occupation, or pursuing academic studies. They are taught not only to find themselves, but to better their condition. The environment is as homelike as it is possible to make it.

A great many men who went into the Army have developed tuberculosis and other diseases requiring special treatment. The Public Health Service has separate hospitals and sanatoriums for these patients, where they may get the best treatment known to medical science.

A large number of soldiers are not yet aware that the Government offers them free treatment. Please tell them.

A MESSAGE TO THE BOYS.

The American boy is a product of the American school. He is at the age then, between fifteen and twenty years when he will make himself physically strong or weak, and form the ideals and habits that go with him through life.

It is for this reason that the United States Public Health Service has started a campaign in America to reach all of the boys between the ages of fifteen and twenty years and interest them in a campaign to keep themselves physically fit. This is not with an idea of raising the boys to be soldiers, but because there is one young man in every

three physically unfit, not only to be a soldier, but anything else that requires strong, vigorous manhood. This was revealed when the army had to reject one man in every three for physical disability.

Surgeon General Ireland, of the Army, and Surgeon General Braisted, of the Navy, have taken a very keen interest in this work, which has the backing of the Y. M. C. A., churches, welfare organizations, and educators throughout the United States, and have sent the following messages to the boys within this age group:

"SURGEON GENERAL RUPERT BLUE,
U. S. PUBLIC HEALTH SERVICE,
WASHINGTON, D. C.

"Sir:—I am just informed of the plan for a great work which your Service is trying to put into effect, to reach three million boys between the ages of fifteen and twenty with a *Keeping Fit Message*. This appeals to me as an effort to meet a striking need. Our experience with an army representing a cross section through the manhood of our country convinces us that the greatest factor in the prevention or spread of venereal disease in the army is the mental and moral attitude of the men.

"In general, a man's mental and moral attitude, his character, is largely the result of the influences which have molded him before he reaches the age of military service, and it can be improved afterward with difficulty and usually only by means which stir him deeply. Heretofore the formation of his viewpoint and standards in relation to sexual matters has been too much the result of chance impressions gathered from uninformed or evil associates, with the result that in far too many instances misinformation and false standards obtained.

"I wish your Service the greatest success in this new undertaking and believe that the results of such success will later be shown in lowered venereal rates in the army.

Very truly yours,

(S) M. W. IRELAND,
Surgeon General, U. S. Army."

"My dear Surgeon General Blue:

"I have great pleasure in endorsing your movement to arouse the boys between fifteen and twenty years of age to a full sense of what they owe to themselves and the country. My message to them is:

"The habits of a lifetime are formed by what you think and do each day as young men; by the companions you choose and friends you make."

"Strong bodies, firm purposes, noble ambitions are your fortune. If you throw away your health by evil ways and soil the purity of mind and body for the amusement and excitement of the moment, you are like a man spending his capital instead of investing it."

"Work hard, play hard. Keep busy, keep clean."

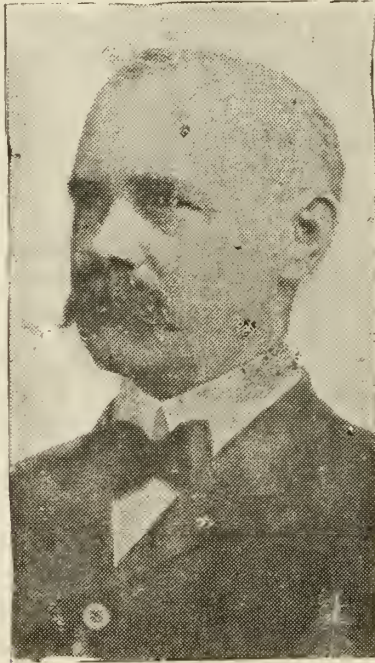
(S) W. C. BRAISTED,
Surgeon General, U. S. Navy.
U. S. Public Health Service."

Necrology.

SELDEN FREDERIC GREENE.

SOLON, 1857-1919.

This well-known practitioner and surgeon of Somerset County, at one time President of the County Society, was born in Athens, Maine, October 15, 1857, the third son of Frederic and Jane Hight Greene, and he died suddenly in his home at Solon, Friday, September 19,



1919. He was sitting in his office as usual after lunch, and talking about future plans with a young lady, who, then passing into the next room, almost immediately heard a curious sound, stepped back into the office and found Dr. Greene dead in his chair, just as she had left him.

His career in life followed this direction of events: He attended in childhood the local schools, was educated at Somerset Academy, and then, taking early to medicine, he obtained his degree at the Bowdoin Medical School in 1879. At his graduation he presented a thesis on the "Diagnosis of Pregnancy," a topic which was of life-long interest to him. He added to his Maine degree by obtaining a second at the Medical School of the University of New York in 1880. He came home to Athens, practiced there for a year, and then moved into the wider field at Solon, for life.

He was greatly given to reading, and reading over again, books on

IN TYPHOID PNEUMONIA INFLUENZA

and other diseases most frequent at this time of year

“Horlick’s”

THE ORIGINAL

Malted Milk

IS EXCEEDINGLY USEFUL

as it supplies the necessary nourishment with the least tax to the digestive system and is agreeable to the patient.

Obtain the *Genuine* by always specifying “*Horlick’s*”

medicine and surgery, on curious cases and operations, on educational topics, and especially those which as a boy he had thumbed over at the Academy. He was an industrious man, never idle. One thing done, he went on to another to be done. His temper was even; he was never angry. He was an excellent surgeon, knowing when to operate and when to abstain. One who followed him from patient to patient for eleven years never knew him to lose but a single patient on the operating table. His results were good, though some of his work was accomplished under unfavorable surroundings. He operated carefully, but was never slow nor tedious, always bearing in mind the chances of shock to the patient from finical details.

Dr. Greene was firm in his opinions. He wrote a well-balanced paper on the eternal differences between hospitals and surgeons, claiming for himself that no patient should be operated upon gratuitously by any surgeon in any hospital, without the operator knowing the patient's means. If the patient could pay, he should pay the operator first, the hospital bills later.

As President of the County Society he kept things moving, and the discussions alive.

He married, October 16, 1884, Miss Jennie Whipple, who died April 29, 1916. He was planning to marry again when death intervened. He was a social man, and to him the best part of any long journey was to get home again. A glance at the halftone above reveals a man to be trusted in any and every emergency.

County News and Notes.

PENOBSCOT.

PENOBSCOT COUNTY MEDICAL ASSOCIATION.

The regular monthly meeting of the Penobscot County Medical Association was held at the Bangor House, Jan. 21.

Dr. Norman Cook, of Newport, was admitted by transfer from Waldo County.

The application of Dr. Raymond V. Bliss, of Blue Hill, was referred to the Board of Censors.

After the business meeting the gathering adjourned to the dining hall, and after dinner the association listened to a very interesting and instructive paper by Dr. Carl J. Hedin, Superintendent of Bangor State Hospital, whose subject was, "Some Current Misconceptions Regarding State Hospitals."

HARRY D. MCNEIL, M. D., *Secretary.*

SAGADAHOC.

SAGADAHOC COUNTY MEDICAL SOCIETY.

The regular quarterly meeting of the Sagadahoc County Medical Association was held Wednesday evening, Jan. 28, at the Colonial Cafe, where an excellent dinner was enjoyed. Dr. Leverett D. Bristol, Commissioner of the State Department of Health, was the after-dinner speaker, and discussed the health conditions in Maine, presenting a very able and instructive paper.

SAGADAHOC COUNTY DAUGHTERS OF HYGIEIA.

Daughters of Hygieia, an organization composed of the wives of Sagadahoc County physicians, whose activities were stopped in April, 1917, by the war, are to resume meetings and active work at once, this having been decided at the fifth quarterly meeting, Wednesday night, Jan. 28, at the home of the president, Mrs. Warren E. Kershner, 57 Green street, Bath, when she entertained with a delightful course supper at seven, after which the business followed.

Mrs. Kershner was re-elected President and Mrs. Clarence A. Peaslee Secretary and Treasurer. The organization is to turn its attention for the present to the Nurse's Home at the City Hospital, which is in need of furnishings. Mrs. Harry F. Morin and Mrs. Seth S. Mullin are to look into the matter at once and learn what is most needed there, after which the Daughters of Hygieia will take the matter under consideration and adopt plans for meeting the situation. A public card party has been suggested.

Members of the organization in attendance besides the hostess were Mrs. Edwin M. Fuller, Mrs. Harry F. Morin, Mrs. Seth S. Mullin, Mrs. Byron F. Barker, Mrs. Robert C. Hannigen, Mrs. Clarence A. Peaslee, and the guests were Mrs. Frank N. Whittier, of Brunswick, and Mrs. Frederick J. Patton, of Bath.

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B&B sterile dressings are sterilized in the making. Then, after wrapping, they are sterilized again—by live steam following a vacuum.

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Notices.

THE UNITED STATES CIVIL SERVICE COMMISSION.

The United States Civil Service Commission announces an open competitive examination for physician, on the above dates, at the places listed hereon. Vacancies in the Panama Canal Service at the salaries indicated, and in positions requiring similar qualifications, at these or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer or promotion.

The entrance salary is \$200 a month; promotion may be made to \$225, \$250, \$275, \$300, and to higher rates for special positions.

Both men and women, if qualified, may enter this examination, but appointing officers have the legal right to specify the sex desired in requesting certification of eligibles. For the Panama Canal Service male eligibles are desired.

Applicants must be unmarried; must have graduated from a recognized medical school whose graduates are eligible for commission in the United States Army; and must have had at least one year's post-graduate hospital experience.

Statements as to training and experience are accepted subject to verification.

Applicants must have reached their twenty-second but not their thirty-first birthday on the date of the examination. Age limits do not apply to persons entitled to preference because of military or naval service.

Applicants must submit to the examiner on the day of the examination their photographs, taken within two years, securely pasted in the space provided on the admission cards sent them after their applications are filed. Proofs or group photographs will not be accepted. Photographs will not be returned to applicants.

Before being permitted to sail for the Isthmus appointees must undergo a rigid examination by a designated physician after the appointment has been actually issued. There will be no charge for this examination, but the appointee must pay his transportation to the place of examination. The official physicians are located at the ports of departure and in a number of the large cities throughout the United States.

This examination is open to all citizens of the United States who meet the requirements.

Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., or to the Secretary of the United States Civil Service Board at any place listed hereon. Applications should be properly executed, including the medical certificate, but excluding the county officer's certificate, and filed with the Commission at Washington, D. C., in time to arrange for the examination at the place selected by the applicant.

COUNCIL PASSED.

The attention of our readers is called to the "Council-Passed" announcement of The Abbott Laboratories, on page IV. We bespeak for this advertiser the support and patronage of our members. This firm is doing splendid research work, and the scientific products which it is developing include medicinal chemicals never before made in this country.

The research laboratories of several universities are co-operating with The Abbott Laboratories, to aid them in presenting to the medical profession original, scientific ideas in medicinal chemistry.

Judging from the growth of The Abbott Laboratories, this original, scientific work is being appreciated by the medical profession.

PAMPHLETS RECEIVED.

We have been honored with various pamphlets, which we gratefully acknowledge and annotate them briefly to this effect.

Dr. Eliza A. Mosher sends a summary of medical and surgical development of the war, the topics discussed being treatment of war wounds, first, by antiseptics, then in sequence by wound drainage, hypochlorites, the Carrell, Bipp, and Morison methods, then by flavine and pastes, wound excision, primary suture, and finally selection, adaption and standardization. Anæsthesia, joint lesions, trench fever, fractures, care of convalescents, orthopædics, and education of the disabled come in for notice. The pamphlet is, in fact, a perfect summary of Bainbridge's (U. S. N.) larger documents, and makes a work for handy reference.



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Whole grains are sealed in huge guns, then revolved for an hour in 550 degrees of heat. The trifle of moisture inside each food cell is thus changed to steam.

Then the guns are shot and the steam explodes. Over 100 million explosions occur in each kernel—one for every food cell.

The grains are puffed to bubbles, eight times normal size. They become flavory tidbits, thin and crisp and flimsy. And every granule is fitted to easily digest.

So with all the Puffed Grains. All are steam-exploded. All are delightful foods. You find many conditions where such foods are ideal for your purpose.

The Quaker Oats Company
Chicago

**Puffed Wheat
Puffed Rice
Corn Puffs**

A pamphlet on cancer by the U. S. P. H. Service offers late information for the public, and should be read by all over 30. Amongst other valuable suggestions we note that persons afflicted with apparent piles should be examined to assure themselves that the trouble is not incipient cancer of the rectum.

The League of the Red Cross issues a valuable pamphlet of activities up to 1920 and invites all to a general meeting at Geneva, March 2—near at hand.

The Rockefeller Foundation asks us to note the fact that four Czecho-Slav physicians are now studying the U. S. P. H. Service, and commends them to practitioners of medicine as Drs. Bernard, Pale, Hulka and Driml. Several Chinese physicians are also at the Rockefeller.

ALL EYES ON MISSOURI.

"All Eyes on Missouri" is a P. H. S. document showing how child-hygiene is being studied out there, by a house-to-house scheme, which promises well. This is something that Maine should have, were the law not obstructed by the rider which kills its utility, because it cannot be done without money. We even prohibit in this way good-hearted volunteers. Truly, it is high time that Maine awoke to the needs of physical examination of the children.

We have also been asked by the Treasury Department to call attention to the work accomplished by 132,000 physicians toward prevention and cure of the venereal, and asking them to continue to report their cases and to keep the public interest unabated. Nurses, druggists, colleges and medical journals have all been appealed to, and all have given abundant help. It is only by reading Reprint 561 from the P. H. Service Reports for October, 1920, that we can get an idea of what sort of an active, admirable and effective campaign has been carried out against this insidious disease, which runs through generation after generation in various ways.

NEW AND NON-OFFICIAL REMEDIES.

Gilliland Laboratories:

Pasteur Anti-Rabio Vaccine-Gilliland.

Pneumococcus Vaccine Immunizing-Gilliland.

Eli Lilly and Company:

Chloroxyl.

Parmele Pharmacal Company:

Chinosol and Chinosol Tablets.

E. R. Squibb and Sons:

Thromboplastin Hypodermic-Squibb.

Winthrop Chemical Company, Inc.:

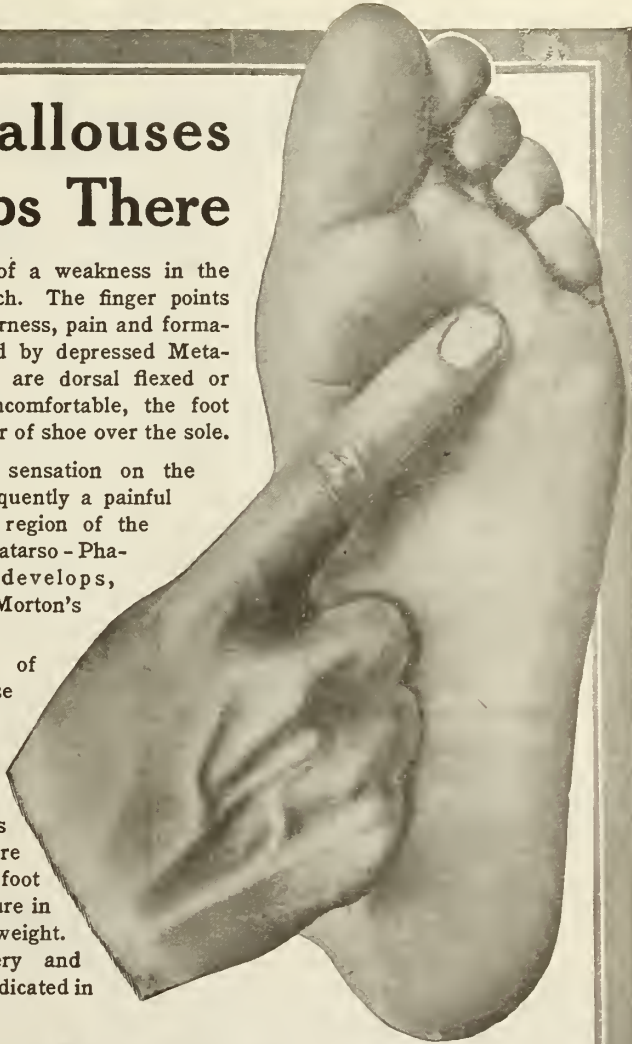
Veronal-Sodium.

Pains, Callouses or Cramps There

are a usual indication of a weakness in the Anterior Transverse Arch. The finger points out the location of tenderness, pain and formation of callosities caused by depressed Metatarsal heads. The toes are dorsal flexed or cramped, shoes feel uncomfortable, the foot widens and spreads upper of shoe over the sole.

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are sold by leading shoe dealers and surgical instrument houses throughout the country, who have also been instructed in anatomy of the foot and how to adjust the appliances.

Write for pamphlet, "Foot Weakness and Correction for the Physician," and instructions for ordering by mail.

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THE JOURNAL

OF



THE

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The Official Organ of the State and County Medical Societies.

VOL. X, No. 8.

MARCH, 1920.

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THE MEDICAL BULLETIN

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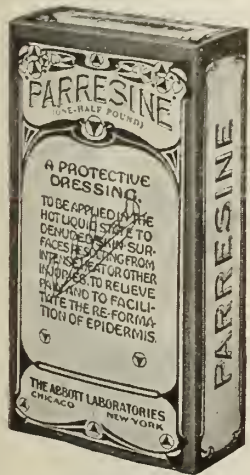


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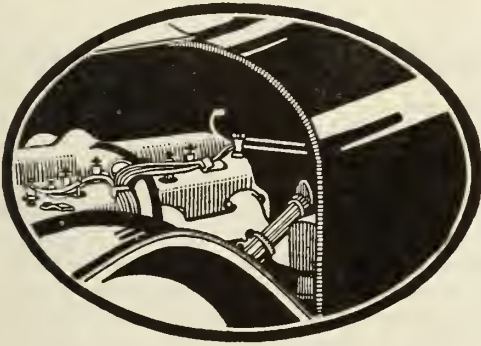


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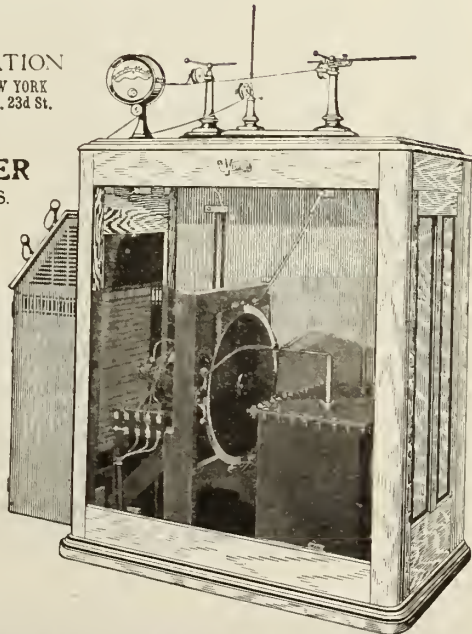
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*TREATMENT IN TUBERCULOSIS.

By C. B. SYLVESTER, M. D., Portland, Me.

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Socially and economically the treatment of tuberculosis is prophylaxis, and the solution of the great world problem will be prevention. When every human being and his children after him shall be cared for in wisdom every hour from date of conception, then can discussion of treatment in tuberculosis be omitted. Till that millennial day there is need of advancing every means for efficiency in treatment of the Great White Plague. Treatment, therefore, as we now consider it, will mean of the relative little which will be left after prophylaxis has accomplished all that could and should be accomplished. Treatment is the management of surgery and medication, the artifices of man, and the management and control of the natural agents—food, air, rest and exercise.

These are the material factors in treatment—well known, simple, discussed till threadbare, accepted as standard, and fairly comprehensive. Yet these can be reconsidered with advantage, not only to get the changing viewpoint of the student, but the actual working out of previously accepted means of treatment among the large bodies of men in our military hospitals. It must be that we have learned something about tuberculosis, possibly something new, but a surer and clear-

* An abstract, with notes on morale and reconstruction. Read at Atlantic City session of National Tuberculosis Association, June 17, 1919. Published by permission of Surgeon General.

er knowledge of many things we believed before. We have had the opportunity for continued military control of these patients who need control, and when they need control. We hope it is made clearer to the medical profession why a tuberculous patient needs a controlling authority outside his own will, but we have only proved what was known before, that the greatest factor in the treatment of tuberculosis is "morale." And if in this classification of agents in treatment I omitted "morale," because intangible, I should be prejudicing its relative importance. The term "morale" is often used meaning "Esprit de corps" of a hospital or a military unit, but in this connection we mean more—the psychic response of each patient.

The control of tuberculosis in the War Department has brought a standard of diagnosis never before known to a larger number of doctors than ever were specialized in two years. Before the war a report of physical examination of the chest had little value other than that due to the standing and reputation of the examiner. But now the army form "55g," signed by a tuberculosis examiner or ward surgeon, carries a definite statement of physical findings which can be interpreted into diagnosis, regardless of the identity of the examiner.

A standard of diagnosis naturally is followed by a standard of treatment. This is in the process of evolution, and has been obtained largely by elimination, by discarding the irrational or useless. Evolution does not mean destruction alone, and negation must not symbolize the end of scientific or rational study in therapy. Instruction to do nothing is depressing in mental effect. Skepticism gets nowhere. Treatment must be affirmative, and patient and physician can truly be inspired by results. Let us appreciate that treatment has not been narrowed in tuberculosis hospitals but extended in scope. We are learning the advantage that comes from continued "hold" over a sometimes irresponsible patient. We are learning the new and the true in reconstruction—occupation versus hospitalization. We are teaching more universally that the acquisition of immunity to tuberculosis comes to us through a one-time infection with tuberculosis; that this is not necessarily an evil but nature's way of protection; that there is small need of tuberculin, for 90 per cent. of us already are tuberculized. Therefore the safe acquisition of tuberculosis immunity is the most important therapy for all whom prophylaxis cannot protect. And if prophylaxis can prevent a massive infection—too large a dose at one time—it will have accomplished more for the safety of the individual than in an attempt to shut the door of the world so closely that no contact with tuberculosis will be possible.

TREATMENT.

A—SURGERY.

The treatment of pulmonary tuberculosis could not be considered without an acknowledgement that the treatment of the other forms of tuberculosis is largely surgical. Bone and gland tuberculosis, so common in early life, must be called surgical diseases, even if treatment by open air and feeding is necessary. The earliest fatal form of tuberculosis is meningitis, in which we can only lament the failure of prophylaxis, but the other forms of later childhood in glands, bones and joints give a wonderful opportunity to the surgeon. Of the very positive and beneficent results of operative surgery in such cases we can speak with keen appreciation. When a tuberculous focus or massive glandular deposit can be removed safely, who can dispute its wisdom? The removal of infected cervical and axillary glands—of a tuberculous testicle or even a kidney, are striking demonstrations of ideal treatment,—absolute destruction of the concentration camps of the enemy.

In pulmonary tuberculosis, aside from complications and from pleuritis, which may be classed as tuberculosis, little surgery has been attempted. The operation of artificial pneumothorax is the only conspicuous operative procedure practiced on tuberculous lungs. It is the proper and logical treatment for cavitation with hemorrhage in a single lung where the other lung is capable of carrying on respiration. Like other surgical practices it has been done unwisely, and for this reason was not unqualifiedly recommended in general tuberculosis treatment by the War Department. It has strikingly and promptly given months of life in comfort to very many patients, and in certain carefully selected cases been a factor in cure. This treatment should be in the hands of competent tuberculosis experts and it should be distinctly understood by the patient that frequent and continued repetition would be needed under observation for many months.

B—MEDICATION.

It is well for us to first understand, where treatment is directed to increasing the resisting power of the patient and his general strength, that medicine can play little part. Resistance must be constant and continuous, hence,

(a) *Stimulants and Tonics*, which are temporary in effect and may be followed by reaction, are useless except as aids to appetite.

Specifics. Their day is past, yet we find a popular demand for Cod Liver Oil, Creosote, Iodine, hypophosphites and glycerrhosphates,

all of which medications are ethical and in selected cases helpful. They are not here condemned, but no one must be misled into believing them cures for consumption. There is no good reason for taking up time and space in the consideration of their relative values.

(b) *Digestive Aids.* Anything which really helps appetite and digestion is of material assistance. There are many mild, agreeable, bitter appetite enhancing preparations of which each physician has his own favorite. None should be given continuously. And we must admit that well-cooked, attractive food, tasty service, pleasant companionship, and a cheerful mind are the best medicines in the long run for promotion of a high degree of food sufficiency and efficiency. Over acidity should be corrected and the use of soda and magnesia in various combinations cannot be condemned unless they are continued, when a change in dietary would bring about proper gastric secretion. There is a quite common anorexia in active febrile-tuberculosis which needs *only* absolute rest in bed in open air and cessation of forced feeding for improvement. *All* functions need rest.

(c) *Laxatives.* On account of the tendency to overfeeding there is a greater need of laxatives, and no intestinal toxemia must be allowed to develop. The regular daily action of the bowels must be maintained in as normal a manner as possible. It can be left to the good judgment of the physician to adapt to the patient that agent which is least disturbing to digestion, and least likely to be followed by reaction.

(d) *Astringents.* Diarrhea is an alarming symptom. Be sure it is not due to faulty feeding, and correct all causes for functional overaction. Intestinal ulceration as a terminal complication is often symptomless. The earlier lesion is more painful. When confident that tuberculosis is the only cause for diarrhea, be prepared for a rapid loss of weight and strength. Digestion and assimilation are so essential in tuberculosis, that when they weaken the last defence is gone. "Descensus in Averno facile est." Treatment has been extensive and varied. Many remedies mean useless remedies. Morphine and bismuth remain standard, though bismuth is even of little use.

Cough. In tuberculosis, it must be taught that coughing is a harmful and improper act; that it *can* be controlled, and that it is an evidence of mental weakness *not* to control it. This is especially true in institutions where one reacts upon another. It must be intelligently explained to the patient *why* he should not cough and *how* he can control it, with specific instructions in method of control. If despite this there is cough, what is the best medication? My personal direction has been hot water

as hot as it can be sipped. Do I succeed in limiting all cases to that? By no means. It is not always convenient, but the nearer any medication is kept to this standard of simplicity the better. Aromatic spirits of ammonia and glycerine is in popular use with my patients. The rest from a racking cough that is obtained by codeine and other morphine derivatives is undeniably beneficent and is occasionally necessary, but the widespread evils from doping a cough are so manifest as to need no statement here. When death is sure relieve all pain, assist sleep. Scientific treatment is past. "Let the quality of mercy be not strained."

Hemoptysis. Hemoptysis causes the greatest fear and alarm. Convince the patient that it always stops when vascular tension relaxes. In ordinary cases assurance is enough; no medicine is necessary. Nitrite of Amyl is in popular use in all military hospitals. It at least has a good psychic effect. If hemorrhage continues, use morphine $\frac{1}{4}$ -grain hypodermically, once only. Repeat effect if desired with bromide of soda. Artificial pneumothorax is the only radical treatment and is permissible as before described.

C.—Food.

You have little need to teach good feeding in America. If there is any one idea in treatment which the public has grasped it is good feeding. In fact, you must be on the watch for overfeeding. There is nothing to be gained in crowding down a second meal while the stomach is still at work on the first. On the other hand, when combustion is great under forced draught, a larger amount of fuel is burned.

An eminent authority said before the war, "Tuberculosis patients cannot be treated like soldiers in the Army." But we *are* treating them in the Army with surprisingly good results. What is the Army hospital rule of diet? Simply and universally "Three meals a day." All rules have exceptions, and milk or egg nogg may be added at bedtime only. Limited liquids can be given more frequently.

Highly nourishing liquid foods, quickly available in the circulation are popular, but the judgment of the physician in each case must direct. While eggs and milk still remain the most valuable articles of diet they must not be given "ad nauseam." As tuberculosis is a disease which should remain under treatment a year, at least, we must anticipate the fact that even a normal person tires of routine; and not create a disgust for valuable foods necessary in the future. In private practice it should be easy to change the menu frequently. In sanatoria it must be done, though we personally realize the greater difficulties in avoiding sameness of diet. It is a matter of wise nursing which

need not be mentioned, that the patient should not be coaxed in constant consultation, but should have the tonic effect of surprises in diet. We differ in tastes and no rules can be laid down. Some patients can drink milk freely for excess nourishment, some cannot. Many prefer butter-milk and find it more appetizing and digestible.

More food can be taken when one is in the open air, so *OPEN AIR LIFE* is necessary to good digestion.

D—AIR AND CLIMATE.

The general public appreciates the advantage of pure air as directly concerned with its effects upon diseased lungs, but does not realize the assistance to appetite and digestion. The atmosphere in different areas and altitudes has been studied in its effects upon tuberculosis until this result is established; *that* atmosphere and *that* climate are best in which one can live in the open air *all the time* with the greatest happiness and comfort, and with the least expense of personal energy and means. In southern California the Creator is worshipped for having granted them the only perfect climate. At Denver and Colorado Springs they are sure nothing could be more health-giving than the clear atmosphere of their high altitude. In Arizona we believe their convincing statements about the superiority of their dry climate, and in North Carolina and Florida we hear of the advantages of mild climates and lower altitudes. In fact, our education in climates has been influenced by the local "boomer" and advertiser. And now on our northern mountains from Maine to Washington we build our sanatoria and even boast the advantages of refrigeration in tuberculosis. The fact is, we are *all* right.

E—EXERCISE.

Exercise is a factor in treatment much discussed of late, which used unwisely is more dangerous than drugs. When a tuberculosis patient can without injury do any work he should do it. It is better that he should gain the confidence of doing it. He must not be allowed to feel that on account of his prolonged rest he is labelled "useless." The disease is bad enough without having the stigma or associations ruin the usefulness or happiness of a life. The Army plans to avoid the unnecessary chronic invalidism which has hitherto been too common. It is teaching occupation therapy with proven success and is doing a wonderfully philanthropic work in teaching men a better, safer and often more remunerative occupation.

Occupation of mind and muscle is a therapeutic factor in chronic diseases of greater importance than we have recognized. There has been an endless discussion the past year over when to change from

rest to exercise. The line of demarcation has been indicated by the subsidence of pulse and temperature to normal, but no rule is absolute. Some mental occupation may be wise *before* the temperature is normal, especially after a long restraint in bed—even handcraft. But a pulse or temperature response, or display of nervous excitement in manner, are quick contra-indications.

Some of us are more conservative than others and feel that a few weeks "playing safe" is time well spent. However, our well trained staff of aides begin the therapy of occupation under medical advice, so gently and gradually that it may be likened to the process of normal growth, and many men will show improvement in symptoms, with a renewed interest in life and a desire to help "play the game."

Those of us who have been in a position to report on relapses observe that errors have been made in abbreviation of initial rest, or in too prompt return to activity, at the insistent demand of the patient. Physical signs and symptoms, certified by the attendant, must remain the guide, and *not* the patient's desire. The man who does not wish to do anything, and who is losing interest in life, is the one needing the valuable assistance of the trained aides furnished by the Reconstruction Service.—After all, exercise is secondary, for it follows initial cure, and initial cure requires—

F—REST.

Tuberculosis has been said to be a disease of the *poor* and overworked. We know it is also a disease of the *rich* and overworked, therefore overwork is the common factor. A continuous temperature elevation requires rest. A quickened pulse requires rest, and rest should be absolute. *Absolute* rest can be had only by *absolute* control. Whether military or moral, there must never be any doubt in the patient's mind about obedience. Many a tuberculous patient exhibits an exaggerated mental activity, even prides himself upon it, or thinks it proof of his peculiar disposition, and tells how "nervous" it makes him to stay in bed, honestly thinking the bed tires him because weariness overpowers him in bed, after the nervous strain has relaxed. In private practice it is almost impossible to secure obedience from women as well as from men. Remark to a woman who requires *only* rest for treatment, "You need one thing to cure you—a broken leg—and if I could do my whole duty by you I should see that you had it. Six weeks in bed will cure you and nothing but a broken leg will make you stay in bed six weeks." "Well, I will keep real still six weeks." And when you call again she will have on a dressing gown entertaining a caller and you drive her to bed. Next time you see her she will be sitting up in

bed reading a novel that furnishes the mental excitement she craves. You recognize this as a common experience, showing the difficulty of control in private practice. You must figuratively knock such a patient down with a club. One with a broken bone knows he must keep it still for it to heal, and, knowing it, mentally acquiesces in keeping still. One with an injured lung should know as much: if he does not, teach him. I cannot put too much emphasis on the need of rest in active tuberculosis.

The greatest function of the physician is the maintenance of an unflinching *morale* in hospitals or out. Psychical contact, the personal touch, is needed. Not to amuse the patient, or please the patient, or to camouflage the situation is essential, but a constant personal demonstration that you know the road to health, and you know it gets there. Start, if you please, on as clear a statement of physical condition as the intelligence of the patient will permit, and keep going ahead with him. Do not go back to the detail of morbidity. It is a healthful exercise for all of us to look ahead, and not back. Every tuberculous patient is going to die; so is every non-tuberculous patient; so are you and I, but this does not mean that we shall turn around and gaze into that abyss of non-existence from which we once came. To show the road ahead to tuberculous patients, we must walk it ourselves. There *is* a philosophy of life. Teach it, practice it, for the tuberculous patient who practices this philosophy will live, while one who is overwhelmed mentally by constant fear will die, other things physically being anywhere near equal.

Our failures in tuberculosis are, first, failure to look for the simple signs. When found, failure to return to the first principle of life which we practiced as infants: *REST—FEEDING—FEEDING—REST*. Begin at the beginning to reconstruct life.

INCOMPLETE MASTOID OPERATION AS A CAUSE OF DELAYED HEALING.

* By FREDERICK T. HILL, M. D., Waterville, Me.

The simple mastoid operation as to-day performed causes no great concern to the competent otologist. The triad of danger points, so terrifying to the neophyte—through experience and training—prove no barrier to operation. With the diagnosis established and operation indicated there is usually no hesitancy in regard to operative procedure. By avoiding undue delay the percentage of complications encountered is reduced and hearing conserved to a greater extent.

What, then, is our weakest spot in this branch of surgery? With diagnosis for the most part easily established and operation devoid of its terrors, it would seem that the too often extended period of convalescence and the too frequent failures necessitating secondary operation are fields for criticism. Far too often, compared to other fields of surgery, does the post-operative period drag out ten, twelve, or more weeks, and then further operative interference is required to insure healing and a dry middle ear. In the clinic of the civilian hospital this is often lost sight of, for the case is discharged to the out-patient department long before it is completely healed and the dressings are carried on there by someone other than the operator. The experiences in a military hospital have proven a revelation in this respect, for the patient could not be discharged until the mastoid was healed and the man able to perform the full duties of a soldier.

We may consider five or six weeks as good time in which to get complete recovery, but how often do we fail miserably in this respect? Surely there must be some reason for this lapse—why some cases go on to a rapid and uneventful convalescence, and others, apparently just as favorable at operation, lag so discouragingly.

A case that drags along unduly after operation must be considered in the category of failures, since we are confronted with what is really a case of chronic osteomyelitis, with its liability of complications, something we hope to avoid after thorough surgery. We endeavor to preserve the hearing by means of the simple mastoid operation, but with a long continuation of the suppurative process in the middle ear there is bound to be a loss in this respect.

Under the heading of failures are grouped those cases, both excusable and inexcusable, resulting in (1) Death; (2) Complications,

* Read before the Eye and Ear section of the Maine Medical Association. Printed in *Laryngoscope*.

whether requiring operation or not; (3) Extended post-operative period, whether requiring further operation or not.

The first two subdivisions may be really considered together, for it is indeed safe to say that a case does not die of mastoiditis *per se*. The lithal blow is dealt by some complications, such as sinus thrombosis and resulting general sepsis, cerebral or cerebellar involvement, or some metastatic process; meningitis, or brain abscess.

The condition of the middle ear and mastoid at the time of operation must be considered. In this discussion we will disregard the case where operation was obviously too long deferred, where there was a chronic suppurative otitis media and similar extenuating circumstances. Given an acute mastoiditis in an otherwise healthy individual, operated upon in what was considered due time, why should there be any unduly extended period of healing? Three facts enter into this question:

1. The resistance of the individual.
2. The virulence of the infection.
3. The character of the operation.

As we are chiefly concerned with the otherwise healthy individual the first factor need not be considered to any marked extent. The fact that syphilis, tuberculosis and other general diseases retard healing is far too often an easy and plausible excuse used to palliate one's conscience in the case of delayed healing. Debilitation of the patient from long continued sickness may play a most important part in convalescence. Uncinariasis may be a factor. The condition of the naso-pharynx, the presence of adenoids, diseased tonsils, deviated septa and accessory sinus infections and their well-known relation to the delayed resolution of the middle ear must indeed be considered, but if in the otherwise healthy patient we try to place the blame for non-healing on the patient's poor resistance, in the majority of cases we will be sadly in error.

The virulence and type of the infection plays a somewhat larger role, though here again we must take care not to find ourselves hunting for an excuse for our own surgical shortcomings. We encounter a series of acute mastoids within a certain period of time, and, as far as laboratory findings can indicate, of a similar infecting organism. These same cases will vary markedly in their post-operative response in a way unexplained by the nature or virulence of the infection.

By far the leading factor seems to be the character of the operation. It is unnecessary to consider the incomplete so-called mastoid operation of the untrained operator. We are concerned with the modern simple

mastoid operation, the more or less thorough extenteration of the mastoid process.

As commonly considered there are four types of mastoids: (1) Pneumatic; (2) Diploetic; (3) Diplo-pneumatic; (4) Sclerotic.

This last is considered by most authorities a pathological type. It is almost never encountered in the class of cases here discussed. Cheatle objects to the use of this term "sclerosed" or "sclorosis", maintaining that this type is a persistence of the infantile; that in the infantile the "mastoid mass" is either diploetic or dense and in some cases persists as such in the adult without the formation of air-containing cells from the antrum. Whatever the process, what we are concerned with in this discussion is the type of case in which there is a varying amount of either diploetic bone, or dense mastoid mass, associated with an acute mastoiditis.

Politzer gives the occurrence of these in the following ratio:

Pneumatic,	37%
Diploetic,	20%
Diplo-pneumatic,	42 plus %
Sclerotic	(scattering)

In the average clinic they will occur in about this ratio. This is true of the cases from the clinic at U. S. General Hospital No. 14, upon which these observations are based.

The pneumatic mastoid following operation seems generally to rejoice in a shorter and more uneventful period of convalescence than in the other types. Secondary operation is much less frequently required. The cases tardy in healing and those reverting to the operating table are more often found among the diploetic and diplo-pneumatic types. Out of a series of 168 simple mastoids at U. S. General Hospital No. 14, in which the ratio given by Politzer was pretty consistently borne out, there were sixteen cases which came to secondary operation after a long-drawn-out period of post-operative treatment. Of these sixteen cases, two were of the straight pneumatic type, five diploetic and nine diplo-pneumatic.

It is fair to presume a greater degree of success for the primary mastoidectomy in the pneumatic type, for the average aural surgeon will not consider his operation complete until he has followed out every cell and pretty thoroughly exenterated the mastoid, removing all possible foci for recurrence or continued suppuration. In some cases with cells extending forward into the root of the zygoma and over the external auditory meatus even to the temporo-mandibular articulation, or upward and backward into the occipital, there may be considerable difficulty, but with the help of the radiograph a thorough exenteration

is usually accomplished. In the two pneumatic mastoids mentioned above, the operators in each case frankly failed to reach all the cells and re-operation was necessary.

In the diploetic and diplo-pneumatic types we have a different condition to deal with. The operator, upon reaching what he feels is solid sound bone, is apt to consider discretion the better part of valor and stop before completely exenterating the mastoid. In the majority of cases he wins out and the mastoid heals in a varying period of time, but from our observations, in about 12% of the cases re-operation is necessary. The diploe may contain quite as much potential trouble as the cells of the pneumatic type. Unless the mastoid is completely cleaned out to its boundaries, we may have a condition simulating a chronic osteomyelitis, resulting in at least an extended period of healing and possibly requiring further operative procedure.

Let us consider the mastoid as a collection of cellular or diploetic, or dense bone; a matrix, surrounded by the cortex corresponding to the outer table of the skull and on the internal aspect by the plates of the inner table. It is posterior to the hard bony external meatus wall and anterior to the plate covering the lateral sinus. Above is the plate forming the floor of the middle fossa. The cortex of the mastoid surrounds this at the tip and encroaches inward and upward forming the prominence of the groove for the insertion of the posterior belly of the digastric muscle. This cellular or diploetic matrix sometimes extends into the substance of the petrous portion and even to the sphenoid.

As the lateral sinus bends forward and downward, forming the so-called knee, it makes an angle with the floor of the middle fossa above. Sometimes this angle is very acute and the space within is very narrow, with consequent temptation on the part of the operator to overlook this, especially if solid. Doing so may be a cause of continued suppuration and necessitate a secondary operation later. Frequently as the sinus swings downward, inward and slightly backward below the knee before making its exit through the posterior lacerated foramen, there is another angle or space formed between its plate and the prominence of the digastric groove. This is frequently overlooked in operating, the surgeon making a beautiful excavation to the tip from the plate covering the sinus but neglecting to dissect out this important angle. This is a favorable site for a perisinus abscess.

Too many mastoid operations may be likened to sweeping a room without touching the corners. These corners or boundaries of the mastoid should be thoroughly cleaned out to insure healing. Whether pneumatic or diploetic or a combination of the two, the zygoma, the cells or diploe just posterior to the external auditory meatus, the tip,

and the angles between the sinus and the floor of the middle fossa and the sinus and the digastric groove should be as thoroughly exenterated as possible. Leaving these points should no more be thought of than neglecting to open the antrum. The cases requiring secondary operation all showed one or more of these points neglected at the first operation. For the most part, after cleaning these out thoroughly the cases went on to a rapid and uneventful convalescence. One case showed at the second operation an area of necrotic dura where the angle between the sinus and the floor of the middle fossa had been overlooked. He exhibited marked signs of cerebral irritation, soon meningitis developed and death ensued on the third day. Post-mortem examination revealed an abscess of the temporo-sphenoidal lobe. Three cases developed sinus thrombosis. In one the space between the sinus and the digastric groove had been overlooked, in another, the angle between the sinus and the floor of the middle fossa, and in the third both of these places had been neglected at the first operation. A perisinus abscess was found in each case at the neglected point.

In this series of secondary operations four cases presented incomplete exenteration of the zygomatic area; two, of the posterior meatal area; one, of the tip; eight, of the superior angle between the sinus and the floor of the middle fossa; and nine, of the space between the sinus and the digastric groove.

These observations are based upon the work of the Oto-laryngologic Staff at the U. S. General Hospital No. 14, which, because of its connection with the School of Oto-laryngology, Medical Officers Training Camp, Camp Greenleaf, was quite large and of constantly changing composition. The operators were men of training and experience from various parts of the country, and may be well considered as typical of the otologists of the country. As a rule, due to this constant change of personnel, the secondary operation was usually performed by someone other than the original operator. In this way possibly franker and more unbiased criticism was obtained. In practically every case the after-treatment, at least the immediate care, of the case was handled by the operator so that the question of the proper conduct of the case from the operator's point of view can be largely discounted.

In these cases which came to a secondary operation, undoubtedly, the original operator cleaned out all soft or necrotic bone and felt that he had reached the limits of the mastoid. But diploetic or dense bone was left as shown by the later operation, in each case. This diploetic bone, while apparently healthy at that time, contained potential trouble, suppuration continued and later this area became frankly diseased. In no case where the mastoid was completely exenterated, care being taken

to outline the sinus and the boundaries of the mastoid cavity, whether pneumatic or diploetic, was secondary operation required. It was not deemed necessary to uncover the sinus itself, but simply to outline the dense bony plate covering it. Where this was eroded, as in a perisinus abscess, the course pursued was obvious. These cases healed rapidly and went to duty in from four to six weeks. The middle ear would be dry in from two to five days, as a rule.

The method of after-treatment employed seemed of minor significance. The Carrel-Dakin and the Dichloramine-T treatment were tried on a number of cases but without startling results. The main factor seemed to be the character of the operation. By far the best results were obtained in the cases which had a thorough exenteration, regardless of type, and in which the after-treatment largely consisted of "scientific neglect." A clean operation followed by lightly packing the cavity with either plain or iodiform gauze for about five days, after which the packing was pretty much eliminated except for light wicks to the antrum for a few days, offered the best results.

Sometime ago I had occasion to operate upon a mastoid which had persistently refused to heal. The man had had two previous mastoid operations performed by two different operators, the first eight months before and the second four months before. While the middle ear was perfectly dry and had resolved, the wound had not closed but was discharging, and bare bone could be felt with a probe. There was no constitutional disease of any kind and the patient was in otherwise perfect health. The mastoid was of the diploetic type. It had been fairly well exenterated except for the angle between the sinus and the floor of the middle fossa. The continued necrotic process had exposed the dura over the middle lobe for an area about four mm. in diameter, upon which was a small bit of granulation tissue. The angle was thoroughly curetted out and the plate covering the dura was removed until normal dura was found. The mastoid healed in good time, considering the duration of the process and its consequent devitalization, convalescence was uneventful, and the man went to duty in about eight weeks.

The pathologic changes in acute mastoiditis, according to Beck, occur in two ways: (1) Cell route or confluent mastoiditis, and (2) vascular and osteophlebitic mastoiditis. In the diploetic, or sense mastoid, it is more probable that the infection takes place by the latter method. This would explain the necrosis taking place after the first operation, when the area in question appeared perfectly solid, much more readily than the confluent process, especially where ample drainage has been established. However, neither this nor the question of whether the infection reaches this area after operation as a factor

of the continued suppuration, or is already there, possibly latent, is of the greatest importance. The main thing is that this same area of diploetic or dense bone may be the cause of continued suppuration in the mastoid cavity, possibly requiring secondary operation or resulting in untoward complication, and therefore care should be taken to thoroughly exenterate this, outlining the boundaries. Often this is exceedingly difficult to do, for we may encounter a mastoid in which there is what simulated an inner plate but what is really a dense partition in the mastoid mass and having small cells or diploe underneath. As pointed out by Bigelow, the radiograph may be of the greatest possible assistance in gaining a conception of the extent of the cavity, stereographic plates being of especial value. However, if operation is not deemed complete until the solid inner plate, or its underlying substance, if absent, is reached and the boundaries outlined, especially in the angle between the sinus and the floor of the middle fossa and in the space between the sinus and the digastric groove, our efforts will be crowned with a great percentage of success.

CONCLUSIONS.

1. The period of convalescence is mainly dependent upon the character of the operation. This is generally the cause for delayed or non-healing mastoids. Early healing and uneventful convalescence depends upon thorough exenteration.

2. Cases of delayed healing and requiring secondary operation are met with more frequently in the diploetic and diplo-pneumatic types, where there is a persistence of the diploe or "dense mastoid mass."

3. The cause of this is neglect upon the part of the operator of certain areas, this oversight being less likely to occur in the cellular mastoid.

4. The "favorite points" overlooked are: The angle between the sinus and the floor of the middle fossa, the space between the sinus and the prominence of the digastric groove, and less frequently, the zygoma, posterior meatus wall and the tip.

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***A PERMANENT BOARD OF ORGANIZATION FOR THE MAINE MEDICAL ASSOCIATION.**

DR. JAMES A. SPALDING.

No recent medical paper has attracted my attention more deeply than that by Dr. H. P. Marshall, of Spokane, Washington, in which as President of the State Medical Society, he urges that every State should have a permanent Board of Organization, to protect its members from encroachments on their practice, as well as to construct new legislation for the benefit of the public and the profession alike.

Physicians, as we all know, are solitary men who cannot delegate their skill to others. They are not given to organizing like other men. We cannot imagine physicians banding themselves together under oath to defend one another in life and death, yet other men are doing this daily, obtaining benefits and preventing encroachments upon their means of living and right to live.

If we were organized we might have prevented the encroachments, for instance in the addict law, with its nuisances of threats for not paying our fee when we have paid it and can show our receipts in full, or of being prohibited from using a single drop of an invaluable dionin solution in a painful eye without paying a license fee in advance, or of being threatened with a fine for not keeping in public sight our license, unfortunately mislaid in the housecleaning of spring.

Health insurance is weaving its tenacious net around us and our means of living, yet, unorganized, we free ourselves not at all from its meshes. Some States have a yearly registration law, under which physicians have to pay yearly, and if they happen to forget to hand in their fee in due season they cannot practice at all on anybody again until they have paid a \$10.00 fine, whilst their names disappear automatically for an entire year from the State-wide distributed Directory of Practicing Physicians. What becomes of our means of living if such legislation is enacted in Maine!

Against such a possibility, and as well for improvement in health insurance plans, in the addict law, in the Workmen's Compensation Law, and so on, we could fight better through a Board of Organization, permanent in character, than in any other way.

As for constructive legislation, Dr. Marshall recommends higher tests for initial registration, and a second licensure for men who, after

*Remarks before the Cumberland County Medical Society, February 18, 1920.

years of general practice, call themselves surgeons, internists and specialists in various organs, after a few weeks of study and without ever being examined for fitness. He would also, in the Workmen's Compensation Law, suggest that the services of some physicians are more valuable and are worth more for workmen than those of average physicians. He would have freer choice, also, of physicians. To such a list I will add, personally, compulsory physical examination of our school children, under the very law which is defrauded in its usefulness by a worthless "rider," as well as compulsory military training for boys between 18 and 21, which, by the way, is distinct from military service. Girls and boys, also, should be drilled as girl and boy scouts.

Now Dr. Marshall argues that our President goes out of office at the end of his year, that the Secretary may hold over but has no power under the new President, that the County Censors and the House of Delegates and the Council are too large in numbers to be of real value. The Legislative Committee can never be permanent. In a word, Marshall suggests a permanent Board of Organization, to be chosen from the total of the County Censors, or the Council, or the House of Delegates, to be chosen for one, two or three years, respectively, and in this way to carry permanent power, the scope of which is to be plainly defined by rules and regulations. The details of elections, of membership, or duties, can be decided by the House of Delegates in session. Such a Board, it is easy to see, could keep a constant watch over everything tending to reduce the value of medical men to the public health, could propose constructive legislation to the advantage of all concerned, and in a single word would "organize" the profession precisely as other sets of men have already done and are daily doing.

The suggestion from Marshall, of Spokane, Washington, seems to me of distinct value, and I now move that a committee be appointed to study the question of a permanent Board of Organization, and to report at the next county meeting as well as to that of the House of Delegates in June.

The motion was amended by Dr. Vanamee, to the effect that the Committee be appointed by the chair, was accepted by the mover, and the motion was unanimously passed.

Dr. Spalding, Dr. Warren and Dr. Gehring were appointed as committee, with directions to report in due season.

Necrology.

THOMAS FRANCIS CONNEEN.

Portland, 1874-1920.

Thomas Francis, the son of Edward and Mary Burns Conneen, of Portland, was born in that city November 2, 1874, and, like four others of his family, he died suddenly and without a warning from



cerebral hemorrhage January 22, 1920. He had, however, feared something of the sort for many years, and some six years before had been warned of a cystic kidney, so that the latter part of his life was undoubtedly overshadowed by the certainty of an early and of a sudden death. His dread of something of this sort may have contributed to the silent, laconic and reserved character which he gradually developed.

As a boy he was bright and active, much given to books, and was well educated in the public schools as well as at Hebron Academy, where he was graduated in 1897. During his vacations he worked in the Portland post office on a salary which enabled him to begin and to carry through to graduation in 1901 the regular series of

medical lectures at the Bowdoin Medical School. I find that his graduating thesis bears the very unique and curious title of "Trans-missiones Placentæ," and that this, interpreted, means an account of the various drugs and diseases which can be transmitted, and have been proven to be transmitted, through the placenta of the mother to her unborn infant.

Dr. Conneen next spent a year as interne at the Maine General Hospital, where he did well-recommended service for a year, and then settled in Portland for general practice with a predilection for obstetrics. He acted as City Physician for a year or two and was also a medical examiner for Cumberland County for a term of two years.

As his health gradually began to be undermined he decided to limit his strength and economize his vitality by specializing in orthopedic surgery, and set off for Vienna to study with Lorenz, whose name not long before had become famous worldwide for his bloodless operations (so-called) for the reduction of congenitally dislocated femora. Dr. Conneen was first a student with Lorenz and then an active assistant, so that, standing side by side with the famous man, he obtained precise insight into all of his manipulations. As Lorenz virtually said in his certificate to Dr. Conneen in 1910, "What I can do, this young Conneen can likewise do."

Armed then with this certificate, Dr. Conneen came back amongst us, opened his office once more, and now for the special treatment of orthopedic cases. He had in his work a good success, was well sought after, and also obtained some hospital appointment of value, as at the Children's Hospital and at the Maine General Hospital in Portland, and at the Queen's Hospital in Lewiston, which he visited once every week, and on which days he also saw patients in that city. He came before the profession only once, so far as can be discovered, with any of his thoughts for reading and printing, and that was in a paper, "The Neurotic or Functional Spine," which he read, discussed and defended before the York, Cumberland and Androscoggin County Medical Societies. It is printed in the JOURNAL and is a clear description of the symptoms and most judicious treatment. Though not long, it covers the ground carefully and satisfactorily. After reading it he added cases that he had seen.

Dr. Conneen was sturdy in his opinions, brief in expressing them, laconic in speech. Those who consulted him liked him extremely, for he was pleasant to them. He satisfied his patients and they believed that they were getting good results.

In 1905 he married Miss Jane Cunningham, of Portland, and is survived by her and four children.

Six years ago he found that he had a cystic kidney, and in addition to this he knew all too well his family history from a pathological point of view. Therefore he conserved his energies and worked and lived as long as he could, and as it proved up to the very last.

At the head of this brief sketch is a speaking likeness of the man who was given but very little to speaking of himself, but he filled a large place in the hearts of his devoted and friendly patients.

J. A. S.

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*Editorial Comment.***GARLIC, ALLIUM, AMEN.**

Garlic, otherwise prescribed not so many years ago under the Latin name of allium, used then to enjoy considerable fame as a carminative, rubefaciant and antispasmodic. The pharmaceutical authorities of to-day extol it in infantile convulsions when employed as a poultice upon the abdominal walls. It has long had other empirical uses in the practice of medicine, to which, however, we need not refer, as they are antiquated, more or less, only quaintly historical, and passing into the shadows of oblivion. That last word, by the way, reminds us of the very fashionable word much employed by the bureaucracy of the nation, the word "obsolescence." Now allium, fashionably and precisely speaking as of to-day, is an obsolescent medicine. Nevertheless, from Spain a paper has come under our notice in which we find garlic extolled as of great and actual value of to-day under the very curious title of "Amen"—"So be it," as the Hebrews might say, but which we Sherlockize as nothing more than a mirror-word showing off the firm of NEMA, which in Spain is now extolling the virtues of ancient allium. At least, this we venture as an historic guess at the origin of the word, for the very latest panacea, Amen.

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Soberly speaking, now, garlic under this fanciful name is on the Spanish market and looking for promotion into the markets of the medical world as of infinite value in tuberculosis and pulmonary diseases. Many of us recall the use of oil of garlic in bronchitis in our student days. It happens now that the oil of garlic is a perfect germicide. It is inoffensive to the smell and innocuous in proper doses. It can be inhaled or applied externally. It is rapidly absorbed by the skin. It is rapidly absorbed in the blood where it can be found very shortly after swallowing or inunction. It has value for ulcers. It might be used in anthrax. It has promising advantages in tuberculosis, because it will reach germs otherwise untouched by various volatile aseptics. A wise authority insists upon it that the only two cures for tuberculosis are mercury, in the mineral world, and garlic, in the vegetable.

Now propyl trisulphide is the very latest chemical derived from allium and is now to be marketed throughout the world under the name of Amen. If tuberculosis is ever to be cured, it will have to be cured by chemo-therapy. Amen can also be fortified with guaiacol and can be administered by mouth or under the skin. Finally, it comes in capsules, and can be swallowed with ease.

We do not like to praise unduly commercial medicines of which we really know nothing, but we venture to pass forward and along the new substance known as Amen, and those who care to utilize it may find it greatly to their advantage as well as to that of their patients. Truly, it is long since we have discovered any medicine with so curious and so promising a name, for if it is to cure the scourge of tuberculosis, then, according to the Hebrew word, "So be it."

CASES OF ALLEGED MALPRACTICE SHOULD BE PRINTED.

We note from time to time regretful occurrences of suits for alleged malpractice against physicians, members of our Association. We regret, more than their occurrence, the fact that all that happens in the Courts is not handed in to the JOURNAL for comment, discussion, condensation, and putting into some sort of shape, not only for medical history but to aid other physicians in defense of such suits when attacked. In every case of this sort there is much testimony handed in that might be of value to other physicians similarly situated, to say nothing of its additional value to attorneys defending other cases, and likewise to members of the profession outside of Maine. No member loves to see his cases in print; he is probably disgusted enough with them when they are settled, in his favor or against, and he hates the sight or the mention of them, but for all that each suit brings forward something new which may be a precedent for others and also of advantage to a fellow member later on. Then, too, in connection with medical defense, which we hope before long to present as a useful scheme for the Association, it will help out our attorney to know everything possible concerning every case ever tried in Maine. It ought to be a duty for the defending physician in all malpractice suits to hand in to the JOURNAL newspapers containing mention of the bare facts brought forward, and additionally to urge his attorney to present a wider view of the case than is generally picked up by newspaper reporters. Whenever a man fights

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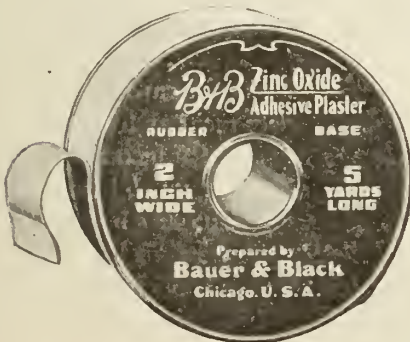
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another man and beats him out, he is glad enough to get into the newspapers in civil life, but a physician seems to avoid publicity even when he has won a contest on which a good many others later on may hang. We believe that all the facts available, all the testimony that can be gathered together, should be handed in to the JOURNAL for the editors to look over, ponder over and ultimately to print the gist and the nucleus of the defense. What helps one will ultimately help more.

THE VENEREAL FEE AND THE PATIENT.

Southwestern Medicine prints in its January issue an editorial annotation concerning the excessive cost to syphilitic patients for repeated injections of salvarsan and other medications of similar nature. The writer argues that when it was first hoped from the discovery of salvarsan that a single dose would cure, the fee as established generally was not too large for benefits received. Now, however, that it has been proved that repeated and oftentimes many injections are needed for a cure patients are getting restless at the large sums of money demanded, an effect which may result in cessation of treatment. The writer goes on to suggest that in all such cases coming under treatment it might be wiser for physicians to explain the length of treatment, the possible number of injections needed, together with follow-up treatment, and plan some definite sum to be paid as the case went along. Most venereal patients want to be cured if they can be, and the monetary intolerance of some physicians almost everywhere in the nation ought not to stand in their path to block it completely.

The JOURNAL is glad to say something concerning such a state of affairs in Texas, at least, and to set it off as a feeler for physicians elsewhere, for surely it is plain that syphilis cannot be controlled or cured unless a standard amount of the latest scientific treatment is utilized to the best advantage.

FREE TREATMENT FOR THE POOR OR FOR THOSE WITHOUT MEANS OF SUPPORT.

In looking over a document from Vienna, of 1910, belonging to our late comrade, Dr. Conneen, of Portland, we were much interested in noting that all patients attending the clinic of the various

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professors in Vienna are provided with a card on which is written above the location of the various consultation rooms in the General Hospital in that metropolis. Underneath it has this very wise arrangement, which institutions at home might very well copy. "Those patients who ask for free treatment because they are without means of paying for it must prove to the authorities in charge of the department, and by proper documents, that they are actually without means of support and really in need of free treatment."

Notes.

On Thursday, March 25, 1920, the Department of Labor and Industry will hold its Tenth Conference of Industrial Physicians and Surgeons in the State capitol at Harrisburg, Pa. This conference promises to be of unusual interest, as it will be the final day of a four-day Safety Congress held by this department, in which speakers of international prominence will participate.

Personal News and Notes.

We are very glad to report a nonsuit granted by the Courts of Maine in a recent case of alleged malpractice in the case of Dr. W. E. Sincock, of Caribou. In this connection we call attention to an editorial annotation on all such instances, with a small bit of advice to those afflicted with such troubles.

Our old comrade Leslie, of Andover, having well established his hospital building work in Roxbury, Mass., has been ordered to Augusta, Ga., to superintend extensive alterations at the Lenwood Hotel, where a large number of war invalids will ultimately be treated for nervous affections. As many as two hundred workmen will be given employment in the changes contemplated, and Colonel Leslie will be in charge. This rest home is one of only two in the entire South. Colonel Leslie has been warmly received by the citizens of Augusta, and will soon speak before their Rotary Club on the objects of the new institution and its work. The local newspaper for February 27 gives our old friend a first-rate editorial notice and send-off, and it will gratify all of his friends in Maine to know that he is appreciated at his excellent medical value wherever he goes.

NEW AND NON-OFFICIAL REMEDIES.

During February the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion in New and Non-official Remedies:

Non-proprietary Articles:

Eucatropine.

Phenacaine.

Gilliland Laboratories:

Gonococcus Vaccine (Polyvalent)—Gilliland.

Staphylococcus Vaccine (Albus and Aureus)—Gilliland.

Werner Drug and Chemical Co.:

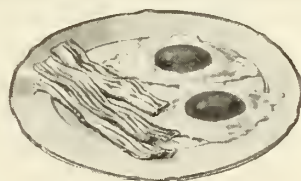
Eucatropine—Werner.

Phenacaine—Werner.

THE PROBLEM OF THE ILLEGITIMATE CHILD.

From time immemorial illegitimate children have been born into the world in spite of attempts to defraud nature of her legitimate purpose that the connection of man and woman shall perpetuate the race. In all this time the problem of what shall be done with the illegitimate child has puzzled the wisest minds. In nations abroad such children have always been welcome from two points of view at least: that the boys shall go into the army and become food for cannon, whilst the girls shall become domestic servants for life or until married, or until they give birth to illegitimate children, when the same program arises for a new generation to investigate.

North Dakota has been known of late years as an asylum for many new ideas, and now it has passed a law for the abolition of illegitimacy in an entirely new fashion. After a long battle in the courts, children born out of wedlock have been authorized to receive the father's name and to be declared as his legal heirs at law. Before this the children's parentage had to be established by proper witnesses, a matter of extreme difficulty, as those who have tried to extort from a woman the name of the man who has caused her to be with child may know by hopeless experience. In addition to the penalty provided under the old laws adopted in other States, the new one legitimates the infant when born. Instead, therefore, of placing upon the State the responsibility for infants born out of wedlock, and branding the innocent victims with shame, the law places the responsibility and the care for life just where it belongs, namely, upon the individual who fathered the child.



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The idea has some merits, but whether to be rushed into by all of the nation remains to be seen. Let the women who ought to make this a study take it up and think it over for its actual value. We must not forget, last of all, that it is not always the father of the infant who is to blame, for some women invite the act which may make them a mother, planning, if it should so result, that they can get rid of the infant when unborn but actually living.

VARICOCELE AND ITS OPERATIONS.

Mowry, in the *Urologic and Cutaneous Review*, reports the results of his examination for genital effects in a list of ten thousand recruits in camp. It is especially interesting to note, tucked away in the end of his report, the very extraordinary remark that there was a high percentage of testicular atrophy following the ordinary operation for varicocele. This would suggest to careful surgeons that they ought to experiment with better methods of performing this apparently simple operation, as prefigured in the text-books of to-day, for with this condition of affairs paternity is practically annihilated, so far as any benefit to the nation is concerned.

DIONIN IN WOOD ALCOHOL POISONING WITH BLINDNESS.

In mild cases of wood alcohol poisoning, in which blindness is the chief or only symptom, it is well to bear in mind that dionin instilled into the eyes may bring about an early cure. Fenton, of Portland, Oregon, reports a case of a man who drank four ounces of what he thought was alcohol, from a bottle in a drug shop, after diluting it with a bottle of ginger ale. This he sipped during an afternoon and evening, and on awakening the next morning he found both eyes seriously affected, vision being limited to noting movements of his hands and fingers at two feet. A drop or two of dionin, 5 per cent., was instilled into each eye, and was continued once daily. In four days vision had improved considerably. Gradual recovery was ultimately obtained with no other treatment. The patient, when well, caused the fluid remaining in the original bottle to be examined, when it was found to be compounded of 90 per cent. denatured alcohol with the rest plain methyl alcohol.

We annotate this case for the JOURNAL in case a patient should appeal to a general practitioner in the absence of a specialist. It is considered wise to deaden the eyes with cocain before the first instillation of dionin, but afterward such a precaution is needless.

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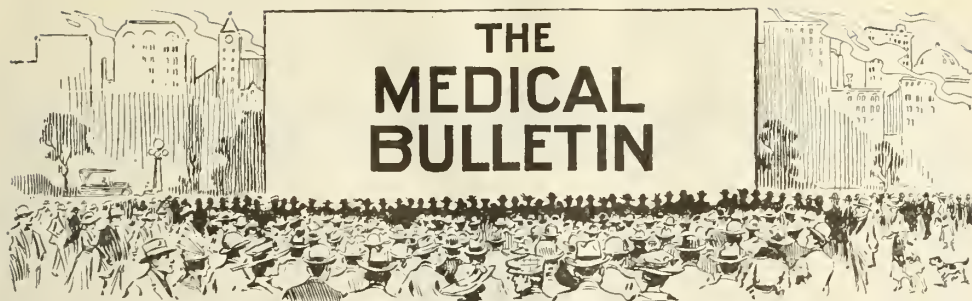
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VOL. X.

APRIL, 1920.

No. 9

*MEDICAL DEFENSE.

By DR. JAMES A. SPALDING, Portland.

Thirty-five years ago I was sued for alleged malpractice in injuring the inturning eye in a case of strabismus. The eye was congenitally defective, but I forgot to call this loss of sight to the parents before the operation. They sued me and won a verdict from an ignorant and sympathetic jury. The case went to the Law Courts on total absence of any evidence of injury and nothing ever more came of it. I paid my lawyer his costs for defending me. Ever since then I have been personally interested in the best means of defense by physicians against similar suits.

Three years ago the Maine Medical Association put me on a committee to study this question and I stand here now to talk medical defense over with you, so that when it is advanced into the county society, or to the House of Delegates or into the annual meeting, you may be able to express some opinion concerning its merits and value. In a brief phrase, medical defense is defense against malpractice suits by a united medical profession.

Ever since medicine became a profession to live by, there have been patients whom physicians have treated with the ordinary skill belonging to the region in which they practiced, but something has gone wrong. The patient is dissatisfied with the results, and consults another physician. That physician, without thinking for an instant of what was the state of affairs in the beginning of the case, takes hold

* Read before Portland Medical Club, March, 1920.

of it as it comes to him,—wrong. He may make various remarks which he never would have made in the presence of the first physician, or if he had had the case as it originally appeared, not as it looks to him now. Such remarks often lead to a law suit against the original consultant. He consults his lawyer, who knows nothing about medicine or surgery, but who begins to study up the case, and it goes to the jury. The case is generally lost because the lawyer is ignorant of the original state of affairs; because physicians appear on various sides, and with opposing opinions; because there is a general opinion that the best doctors may make mistakes, and that many of them take too great a risk with experiments of various sorts.

As time went on physicians became insured by corporations who saw a chance to make money by wholesale insurance of large groups of physicians. These corporations kept it up in spite of the fact that many suits went against them, simply because they were corporations and could afford to pay. Invariably the physician is asked if he is insured and invariably the plaintiff's lawyer argues that a verdict against the doctor, who may have made a mistake in spite of his acknowledged skill, doesn't hurt him because he is insured. Furthermore, he additionally argues that many physicians insure themselves in order to cover over the mistakes which they know they may make from trying experimental methods of cure.

By and by in some State clamor was raised against this insurance because it was a wrong to the public that physicians should be insured against their neglect. Although this latter objection has not yet made much headway, it is plain that it may arise at any time, and for that, as well as for other ideal reasons, some leaders in medicine began to study and to carry out medical defense against all malpractice suits by an ideal of union amongst physicians. These men saw that the saving of money in a malpractice suit by insurance was not everything, but that there was a deeper ideal, that of loss of reputation. Suits went against insured physicians, the public saw the verdicts, they read the damages awarded, they read the perverted testimony of learned physicians against a brother in medicine, yet in spite of the fact that they read that the doctor was insured and that it cost him nothing, the public could see but one vital point, that a rich corporation was paying damages for neglect on the part of the physician in treating a patient who had relied upon his skill to cure him. Medical defense nowadays has reached that point in twenty-six States, in that all malpractice suits are defended by an associated profession who stand behind worthy physicians, and the profession is aided by a single lawyer, who by each

succeeding case is elevated more and more into an expert in medicine and surgery. Such a man not only has the skill for defense, but he announces himself as the representative of the physicians of the State banded together to fight the assertion that they have not done their best to treat patients with the ordinary skill of the community in which they practice.

The question, then, for you to decide is this: Will you simply insure and get rid of the fear of being sued, and then meet with defeat in almost every instance simply because you are insured, or will you stand up with all of us and fight with better chances of beating the prosecutors out of court? It is an ideal, it is true, but it offers many arguments and illustrations in favor of its adoption in Maine.

WHAT DO THEY DO IN MEDICAL DEFENSE?

Let us read briefly the agreement in Massachusetts, our next-door neighbor, and follow that scheme through other States of the Union.

Active members of the society are entitled to receive without personal expense legal advice and the services of an attorney in the pay of the society for defending them everywhere in the State when accused of malpractice. Such services will only be granted to members showing that they have paid all dues. They shall furnish the Secretary with a complete history of the case in which they have been sued, with dates, names and residences of consultants, nurses and others cognizant of the facts. They shall agree not to compromise nor make any settlement without the advice and consent of the society through its attorney, nor shall they employ other counsel without the consent of the society. If they should compromise or settle, then they shall pay for expenses already paid out for their case. The President and the Secretary have a general supervision of all such suits. The society will not pay any indemnities agreed upon by arbitration or agreement, or by verdicts awarded in court.

The blank to be filled out by the applicant is here shown and runs to this general effect in words: "The undersigned, residing at——, hereby applies for defense under the terms adopted by the society in 1908, and in consideration thereof agrees not to settle without the consent of the society through its attorney." He renounces his own defense and gives the society full power to defend and look after his interests. He agrees not to obligate the society to pay any money whatsoever, and will help in every way with witnesses, documents, and by doing all things necessary or proper for such defense. Here follows a list of witnesses available, and annexed is a true, accurate and

complete statement of the treatment by him of the patient and a true history, so far as he can give it, of other treatment received by the patient. He encloses his receipted bills for dues, lawyer's letters, court summons and other documents received by him in connection with the action brought against him. This is signed and dated.

West Virginia offers the same defense with variations to this effect, that there is a board of three members, chosen indifferently by the House of Delegates, serving in such a way by election that the board is ever permanent. This board assists in all suits and furnishes lawyer, witnesses, and pays to them such fees as the House of Delegates may limit them to. When the board has decided that the case is such an one as is fit to be defended, the case proceeds. If the board decides that it is unfit to be defended, the applicant is informed, and he can appeal for a hearing to the House of Delegates, whose decision is final. If there is an adverse decision it is absolutely confidential, being handed personally to the applicant and in writing.

In Pennsylvania, the Board of Councilors of the State society select a permanent counsel with retaining fee. To him shall be submitted all suits. He shall endorse attorneys in various counties, but shall attend personally to all appeals in higher courts. The fees for this counsel are to be paid out of the defense fund, amounting now to several thousands and accumulated by a yearly charge of 75 cents. Members when sued shall hand in application for defense at once to the Secretary and get the blanks. If not filled in inside of thirty days and returned, no attention will be paid to it at all. Every such application shall be then endorsed by unanimous vote of the Censors of the applicant's county after rigid examination of the facts. This endorsement carries with it not only the moral support of the members, but active participation during the trial in any way that counsel may suggest, and without thought of reward. After proper endorsement the management rests with a committee, consisting of a Councilor of the district, the President and the Secretary of the State association. They discuss the case with the permanent counsel and decide as to the continuance or the withdrawal of the defense. The Councilor and the Secretary shall be paid legitimate expenses in time and travel. The applicant agrees to abide by the advice of the attorney and never to settle or compromise under penalty of withdrawal of counsel. No defense will be given to any member except for purely legitimate professional work. The defense will not pay any expenses of witnesses within the county nor any judgments imposed by courts.

The application blank is of wider scope than in Massachusetts and

is here exhibited. It reads to the County Censors first, with history of the case, and treatment, then Censors ask questions which are answered on the blank. Next the Censors sign their opinion, and following it is the applicant's appeal to the Council of the State society. Next comes the Councilor's opinion on the merits of the case, which is approved by the President and Secretary, and the whole form is then passed to the permanent counsel.

The City of Philadelphia has its own medical defense fund, the sum amounting now to \$15,000.00, the annual fee for defense paid into the State medical treasury from Philadelphia physicians being paid over to the Treasurer of that city defense fund for years back. The directors of the city society choose a member of the bar to serve constantly, and the city society offers his services to all members threatened with malpractice suits.

New Jersey causes members in good standing to apply to the Secretary, who shall provide a blank form, which, when verified by him, shall be sent on to the hired attorney. If he favors the case it shall be referred to the Judicial Council. If they favor the defense the attorney shall attend to it, but his fee shall never exceed \$250.00. In case of an appeal after a verdict against the applicant, the lawyer's costs shall be decided by the Judicial Council. If the applicant is probably guilty of malpractice as judged by the Council, no defense will be made. Members carrying insurance, and who may elect to be defended by the attorney of the corporation, shall, nevertheless, be entitled to and should receive the moral support of the Medical Society of New Jersey collectively, through the officers as well as individually.

Missouri compels members sued to inform the Secretary inside of three days, whereupon he and the committee will investigate and defend or not, the fee for defense to be \$100.00. The society pays no fees, damages or expenses except those incidental to the taking of depositions. No case that is legally liable to criminal prosecution shall be defended, nor any suits in which damages are conjointly claimed against a hospital or sanatorium. The defense plan for Missouri is brief and worth copying, with some slight changes, in any State.

Iowa notes to me that many suits arise from members suing for payment of bills for services, and urges members with all such intentions to sue to submit their bills to the society's attorney before suing for the sum due. If advice is also asked, the moment that a suit is threatened or brought, advice by the attorney may cause litigation to be avoided. Whilst local counsel will occasionally have to be employed, this should not ordinarily be done without consulting with the State Medical Committee or the counsel for that Committee.

Nebraska has a standing Defense Committee, including the Secretary and two members chosen indifferently by the House of Delegates, one of them always holding over with the Secretary, the chairman receiving \$300.00 a year and \$200.00 for office and traveling expenses. Medical witnesses shall receive \$20.00 a day and travel costs. A lawyer is hired permanently, and all expenses are paid out of a medical defense fund of \$1.00 paid yearly, the fund being kept separate and never used for anything but purposes of defense. The Nebraska law is complicated, but has good suggestions, amongst which are that the merits of every case shall be judged by the President and Secretary of the county society to which the applicant belongs, together with a third member to be named by the member sued. After searching inquiry they shall, if their report is favorable, forward it to the attorney for defense to the limit of the law.

Ohio is one of the last States to adopt defense and is the first one to say that it will not defend a suit if brought on cross-complaint where the physician has sued for services within a year after finishing his services, nor will it defend homicide or criminal acts, or cases in which X-ray pictures were not taken at the time, unless it can be legally shown that such pictures could not be taken. Witnesses within the county shall not be paid for time, but those outside shall be paid both for time and travel. Members must give moral support in all cases without thought of pecuniary reward, and where the member is insured the association will offer every possible aid.

Let me interrupt my story for a moment to say that at a recent trial in a locality forgotten by me just at present, the defendant physician in a suit testified that there was no X-ray plant within forty miles. The judge ruled that such a distance ought not to have prevented the patient from having their scientific benefit and demonstration. So bear this in mind, fellow members, and insist on carrying your patient even as far as from one end of the State of Maine to the other, rather than to get "stalled" face to face with this judicial opinion.

Indiana has a permanent committee chosen by the House of Delegates, the present chairman, with whom I have had much correspondence, having occupied that position for twelve years. Seventy-five cents are assessed yearly until the fund gets to be \$6,000.00, and then any excess goes to the treasury of the society. The committee have power to defend proper cases, the limit of expense in any one year not to exceed 25% of the fund. Members sued apply first to their county society, in which the President and Secretary and one other member shall decide regarding the chances. If favorable, the case goes

for trial by a hired attorney. If the committee reports unfavorably, the member can appeal to the Defense Committee. I call your special attention to the fact that Indiana also defends suits brought against the estates of deceased members in good standing at the time of their deaths.

Minnesota will defend all members accused of malpractice or of illegal transactions in connection with the commitment of insane persons. The Council shall investigate all such complaints, and if adjustment is impossible or the claim is unjust or damages demanded excessive, they shall defend, hiring a member of the bar as permanent adviser. Otherwise the Minnesota law is like others, but we note that there is no committee, the Council attending to the affairs of this nature.

New York offers us a specimen form in which we can see that there is no committee anywhere in State or county, but that the member applies to the Secretary for good standing, then hands in all papers to the legal representative of the State society, who defends it to the best of his ability, and this has resulted in a record of never having yet lost a single case in the courts of New York in twenty years. What a famous record!

We have now heard the sum and substance of what medical defense really is as it has been established in various States. I might add items from other parts of the country, but believe that you already begin to see some light on this vexed question.

RULES AND REGULATIONS.

We have next to go over in some detail the various rules and regulations issued by various State Medical Societies in regard to the workings of medical defense. For instance, from Iowa I borrow these suggestions. The object of maintaining a defense fund is not to defeat any just claims against our members. We recognize that mistakes occur to the most careful men and the committee uses all just and honorable means to obtain a fair settlement in every case. But as nine-tenths of all suits are purely blackmail, the need of the fund is plain. Each one is interested to prevent blackmail, because every extortion is an encouragement to others. The fund is to aid the members against extortions. The cost of keeping up the fund is of course a burden to many members never liable to be sued, but all ought to be willing to help. I note just here that it is likewise a terrible burden to carry insurance for years when the chances of a suit are so slim, yet we do it. If we can endure the sum of \$15 a year for insurance, we can stand a minimum charge of 75 cents. To resume: Iowa says that

where physicians plan to sue for services rendered, it would be better, first of all, to consult with the Defense Committee, lest a claim for malpractice be filed in counter or cross suit. In case of suit ask for defense at once, and advice may be given that will prevent the whole affair. So, too, the expense of hiring local counsel may be avoided by asking advice of the paid medical attorney.

Wisconsin says to its members: "Send in your case at once to the Secretary and to the insuring company, or to one, or both. We invariably coöperate with the corporation when so desired. Some companies compromise, but we fight every case accepted as honest. Do not talk promiscuously about your case, either to laymen, or to lawyers, or to friends, and not too much to any physicians. By disregarding this advice you may make statements which can be turned against you at the trial."

North Dakota hires a lawyer permanently at \$300, but a committee shall hear and try to settle all suits or to minimize damages claimed. The defense agreement in this State is very strict and verbose, with, however, suggestions of value. Local lawyers are hired by the medical attorney, but they work under his supervision always. The society's attorney is paid \$50 a day in court, but few cases ever come to trial, because the counsel tries hard for adjustments. Members pay \$2.00 yearly to accumulate a fund for permanent medical defense.

In its advice to members, Missouri says that suits can be prevented much easier than defended with success, and urges members, when threatened, to consult with the County Council, who often can be of more avail than any lawyer. Lawyers should try to prevent cases being brought to trial, leaving the initiative to the other side always.

Let me mention here a side issue in medical defense, which is in Iowa discussing the idea of the State medical association setting up its own insurance company, every member to pay for and own a full paid-up share, nobody but physicians to own stock. The idea would then be a corporation with its policy dictated by doctors only, and there would be sufficient money to pay a good attorney of wide experience in all such things as malpractice suits. Possibly the Iowa idea will come to form, and if so, notice will appear in the JOURNAL from time to time.

At this stage in our study of defense various papers were handed by members of the county society not on the Committee for study of medical defense, and after looking them over and discussing with other members the following questions were handed to me. I have corresponded concerning them with many Defense Committees in many States. Here are the questions and the answers:

THE SIX QUESTIONS.

1. In any trial for malpractice where the physician is insured, does not the insurance company insist upon furnishing counsel for the physician? If so, what part would the counsel for the Association play?

2. Who pays the fees for experts called in to defend a colleague?

3. If the Medical Defense Committee consists of members with a large consulting practice, what effect is an adverse decision on their part to defend a fellow member likely to have on their practice?

4. Can impartial men be found to serve on such committees?

5. Are not 75% of all malpractice suits settled out of court by insurance corporations?

6. Who appoints the Defense Committee or does it include President, Secretary, and Councilors?

As you will notice, many of these questions have been answered in one way or another by the various agreements established in various States, but as there is much information of great value on many points in medical defense in letters which I have received replying to these questions, I will now take them up and print them in abbreviated form for your study, consideration and final decision.

Massachusetts says: "Our counsel has nothing whatever to do with the defense of cases insured. We defend only those placed entirely in our hands. We never compromise and we never pay damages awarded. Experts are paid their actual expenses only. As our committee consists only of the President and Secretary, we have no trouble affecting their practice. As to impartial men our answer is plain, that nobody could be more so than the President and Secretary. In regard to compromising we know nothing, but can say that the Aetna is apparently getting most of the business, and, as we understand, invariably contests all suits. Other corporations may act otherwise, but we do not know. As to the appointing of the committee, it is already answered by repeating that the President and Secretary are the committee in perpetuity."

From New York word comes that "If the insurance company defends, the State legal agent has no footing. Medical experts are called by the legal counsel, and in an experience of twenty years I never knew of but one who asked to be paid anything for defending a brother physician. Committees, in my opinion, are unwise, and when a proper history has been handed to the defending attorney he will see at once if there is any chance of winning, and if not, he can be of great help for a compromise. No difficulty, however, will ever be found in ob-

taining high-minded men for committees when deemed desirable. I know nothing of compromises by insurance companies, and to me personally it makes no difference how committees are appointed, or elected, for I am opposed to all committees. Let the Secretary hand the facts to the legal representative and leave everything to him."

Iowa replies that "We do not permit any defense by our committee at all unless the counsel for the insurance company is willing to come in and assist our man. Defense must be totally subject to the society, otherwise the physician takes his chances of a judgment against a corporation. If the insurance companies desire, local lawyers may be added to the assistance of our counsel, but we cannot consent to any divided responsibility. No man has ever yet refused to testify in all of our cases ever tried and in our favor. Very few men in Iowa are insured, so that it is impossible for me to know how many the corporations compromise. Experts we rarely employ unless locally and easy at hand, for we prefer a common, every-day physician who has more jury influence than experts from away who are looked at askant as aristocrats whose opinion is sold to the highest bidder. The jury understand the common, every-day physician better than the experts from a distance."

West Virginia answered our questions to this effect: "If an insurance corporation insists on defending a suit we have associate counsel of our own, but the company generally is willing to pay half the costs of our attorney. Experts have never rendered any bills except for travel, but I have known of instances in which the defendant physician has insisted on paying a reasonable amount for travel and loss of time. As to impartiality, years of testing with defense have shown first, last, and all the time, that every committeeman has been for the defending physician. Of compromises we know nothing, as insurance is uncommon with us. We have never compromised for a single cent so far, nor have we yet lost a single case in court to the end of 1919. Our committee consists of three men appointed by the President from the Association Council." I will add, just here, that West Virginia raises a fund of \$1.00 yearly, the attorney has directions to work in harmony with the man paid by insurance corporations. Many members do not contribute at all to the fund, and cannot, therefore, be defended, and very few insure at all.

HOW DOES MEDICAL DEFENSE WORK?

Having taken much of your time going into all sorts of details, most of them, however, of distinct value in the study of medical defense, I pass to the important topic of how it works out.

A delightful letter from Iowa shall start the subject. "We have no forms, but we have our list of members, and when a complaint is handed in we know at once if he has paid his dues. If not, he gets no defense. If he comes in as a member after he has been threatened we do not defend him, no matter who he may be or what he has to urge. We ask the paid-up man to hand in his story and to come personally and talk it over with us. We then advise together, outline our case, and pass it to the lawyer employed permanently. It sometimes happens, regardless of our notices, that members employ another lawyer than our own to start with. This complicates affairs, but we gradually overcome them. We pay our lawyer \$50.00 a day in court and \$25.00 a day when actually making up his case. Claims to the amount of \$1,600,000.00 have been made against us in twelve years and we have lost just three cases with very small verdicts. We have had 235 cases in all, and the cost in all has been about \$7,500.00 spread over twelve years, an average of say some \$600.00 a year. Our fund is made up out of the annual dues of \$5.00 a member, so that we are laying aside about \$4,000.00 a year after paying all expenses, those of the *Journal* included."

Indiana reports to my questions to this effect: "We get 75 cents from each member yearly and laid up a fund of \$6,000, when we stopped. Some of our members always pay, some take their chances and pay occasionally—some who want to get in out of a threatened suit—but men in defective standing with the defense fund are not defended. Claims go to the Secretary, thence to the President of the local county society and a committee of three in that county, and if recommended, the case goes to the association lawyer. We do everything possible to beat off the suit; we never compromise. We start clear and fight to a finish. We know doubtful points and we avoid them from the start. Every case so far has been won, or is now under appeal, with our chances as good for a verdict as those of the other side. We shall not assess for the fund this year as we have our \$6,000 in bank. We pay our attorney a nominal salary and the Medical Defense Committee serve for nothing, but are paid per diem when actually putting a suit into shape for defense." Let me emphasize, in concluding, news from Indiana, the final paragraph of a recent letter: "Many members carry insurance in order to be doubly fortified, but the attorneys for these companies work jointly and amicably always with the attorney for the medical defense feature of our association."

Missouri results, as so far reported for 1919, were twenty-three cases discussed, eleven being threats, three new, three non-suited, one

with verdict for the physician, two compromised on small damages, eleven outstanding untried still. The longer they hang there, the less the chance of their ever troubling the Defense Committee. Missouri recommends a committee, because it is believed that they know how to set aside difficulties better than a lawyer locally hired. There is no State counsel. The cost of defense is limited to \$100.00. They do not defend when a sanatorium or hospital is equally involved in the suit.

Texas lost no cases last year. Those members who seem to think that they are liable to be sued may think that they ought to insure, but some corporations seem to foster such suits for advertising purposes. It is not for the advantage of a physician to have a judgment against him even if insured, and it is advised that those insuring should ask beforehand if the corporation is willing to coöperate with the Defense Committee.

Wisconsin did not pay a dollar for damages last year. Their experience gained in the past years has proved to blackmailers that their business is no longer to be carried out so successfully as of old. Twelve trials all went for the defendant, at small cost legally. Let me insert that the defense of a member in Wisconsin must be endorsed by unanimous vote of the Censors of the county present at a special meeting called for the purpose after rigid examination of the facts in the case. In the seventy-nine cases so far tried in Wisconsin only five have been lost and those in the early days of medical defense without trained attorneys.

Illinois, I find, tried twenty-one cases in a single year and all went for the defending physician. In only one instance were damages awarded and they are being appealed.

From another point of view I call your attention to a fine letter from New Jersey to the effect that whereas as before medical defense was established the loss in older members was greater than the gain in younger men in the society, there has lately been a decided increase in numbers of men, both old and young. When they saw under medical defense that verdicts were going more in favor of medically defended men than to those who were defended by insurance attorneys, membership increased largely. The old society, which once numbered about 1,000, has increased to almost double the number, owing mainly to medical defense results in the State courts of law, for, as the Secretary informs me, very few juries like to be considered by their fellow citizens as partners in blackmail. Such is public opinion of to-day in New Jersey. Three judges also recognize the honesty of the Society's position, as is proved by the increasing num-

ber of non-suits allowed by them. Furthermore, reputable lawyers are declining such business.

Kentucky reports fine results on the whole. The loss has been \$3,000.00 damages awarded in one period of eight years, damages being mostly \$50.00 to \$100.00, with one larger one of \$2,000 in a case which seemed doubtfully worthy of defense to the committee, but was finally defended.

California's plan for a defense indemnity is so radically different from that adopted elsewhere that I will read it pretty fully as outlined in a letter from the Society's attorney: "The California Medical Society has adopted an inter-indemnifying plan open to members who desire to participate, and a preliminary assessment of \$30.00 each was levied. This is not insurance but indemnity, such an association as the State society being authorized by law to organize. While our experience has been extraordinarily successful in the defense of alleged malpractice claims, the society determined that it would be advisable to adopt this indemnifying method. At the same time the Directors of the society advise members to insure as well. It is not contemplated that the fund will require annual assessment, as our experience would indicate that the society's organization is very effective. Our position is, that considering the very slight cost, members should not waste any effort to determine whether defense by the society without indemnity or defense by the society with indemnity or defense by an insurance company is superior, but should impartially and promptly secure all protection available. We make these comments regarding insurance with the proviso that the society's organization is such that an insurance company in any case handles the individual's claim in conjunction with the legal department of the society, so that the society's representative, thoroughly versed in insurance methods, "sees to it that the member is accorded full and complete protection."

The results in Massachusetts are and have been invariably satisfactory, and the average cost per capita to the members has been about twenty cents a year for the past twelve or fifteen years. The champion of medical defense in that State, the veteran Dr. Gay, emphasizes the steady current of belief in the minds of some eminent lawyers that physicians have no right to insure against their possible mistakes in money damages, admitting that they might insure against costs in court. If this belief increases, time will come when medical defense will be our only protection against malpractice suits, and therefore we should set about it to establish it in Maine.

Last of all as to results, I call your attention to New York, in which success has attended every case so far defended in twenty years without a break. It is a wonder that medical defense against so many suits should have been so perfect. Evidently the famous legal adviser, Mr. Lewis, knows human nature as exemplified in average juries better than almost any living lawyer. From him, then, in conclusion, I offer these words of wisdom: "There is no desire on my part again to refer to the relationship of the members of the Medical Society of the State of New York to the insurance companies. Every member has heard me repeatedly, and read my reports year after year and knows exactly what my feelings are with reference to their taking out insurance policies indemnifying them against losses for negligence. These policies are a very serious menace. The doctors who hold them must remember that the State society may not defend them, and that they must choose between the attorney for the corporation and the whole-hearted defense of the State Medical Society, should they be sued. I have always contended that the money phase of a malpractice case is of the slightest moment, but that the reputation of the physician is of the greatest importance. An insurance company has no interest in the professional reputation of a defendant doctor. "Get rid of the case as cheaply as you can is their prime motive."

I thank you now for listening to an exposition of what medical defense really is, and in conclusion I have drawn up a tentative plan for medical defense in Maine.

TENTATIVE PLAN FOR MEDICAL DEFENSE IN MAINE.

I would have a folded piece of strong paper about six inches by three, and on the front page I should print something like this:

PLAN OF DEFENSE AGAINST MALPRACTICE SUITS OPERATED BY THE MAINE STATE MEDICAL ASSOCIATION.

Medical defense for members of the Maine Medical Association began (insert date).

Members are urged to read the rules and regulations carefully, as it is important to understand and comply with them.

The association will furnish to members in good standing expert legal counsel, will, if possible, prevent the filing of suits, and will bear the expense of defending members in case of a suit for malpractice. The association will not pay damages, but will leave nothing undone to protect its members against a judgment.

Members whose dues are paid up, both at the time of the alleged

cause of the action and at the time of the institution of the suit, are entitled to medical defense by the association.

In order to receive the full benefits of medical defense members must comply with the rules and regulations. In every case, however, the association will do all in its power to help a member who applies for advice or aid.

On the remaining pages of this paper I would print the act and Regulations.

ACT WITH RULES AND REGULATIONS.

All active members of the Maine Medical Association shall be entitled to receive, without personal expense, legal advice and court service from an attorney hired by the association for the purpose of conducting their defense in any court in Maine whenever they are accused of malpractice or of illegally committing persons alleged to be insane.

Active members wishing to avail themselves of the privileges of this act shall apply in writing to the Secretary and prove that they are in good standing by payment of all dues. They shall furnish the Secretary with a complete and accurate statement of their connection with and treatment of persons concerning which complaint has been made against them, with dates of attendance, names and residences of nurses and others knowing facts and circumstances necessary to a clear understanding of all matters at question as may be required by the Secretary or the association's attorney.

Members shall agree not to compromise or to make settlements in any manner without the advice and consent of the Secretary given through the attorney, nor shall they employ other counsel without the consent of the association.

If they shall, without the advice or consent of the association, decide to settle or compromise complaints against them, they shall pay the association for expenses already accrued and in default thereof they shall be deprived of further privileges under this act.

When members shall ask for defense under the provisions of this act, the President and the Secretary together shall have power to grant it, or for evident cause to reject it, as the case may be, and to make such further provisions as may be deemed necessary for carrying out the purposes and intents of this act.

The association will defend up to within one year after his death the estate of any active member in good standing, who was before his death complained of for alleged malpractice.

The association will not defend a suit in a case of fracture or similar injury in which an X-ray plate was not taken and kept on file unless it can be shown that at the time and place it was impossible to take one. Nor will it defend a member believed to be guilty of criminal abortion, foeticide, homicide or any criminal act, or who has not conformed to the recognized ethical acts in such cases.

Where a defense is conducted by an insurance company the association will not contribute expense, but will give all other aid possible.

The association will not assume any responsibility for payment of sums agreed upon by arbitration in settlement of complaints or of verdicts awarded or for making payments for any purpose whatsoever except as herein specified.

Assessments for carrying out the provisions of medical defense shall be decided by rules and regulations of the association hereafter to be voted.

After adoption of this act members shall be provided with rules for guidance when threatened with suits alleging malpractice.

This act shall take effect when approved by the House of Delegates and adopted by the association, and shall apply only to suits based upon professional service rendered after its adoption.

Now, fellow members, such a paper as proposed, subject, of course, to debate, discussion, wording and adoption, could be printed and handed to every member and kept on file. Whenever threatened with a suit he could refer to it and know just what to do.

I do not want to exaggerate my labors in carrying on these investigations concerning the workings of medical defense all over this vast country, but it has not been an easy task, I can assure you. It is done, and you have here the fruits of my labors. I have come here with the idea of putting my labors into a definite shape so that you can, I hope, get a plain idea of just what medical defense really is, what it accomplishes, and what it promises us for the future in case we wish to set up our own insurance, or if corporation insurance should ever be denied us by act of Legislature. Medical defense is the union of members wherever possible, or the promise of some sort of union better than that which we have at present.

In due season this paper, with any remarks which you see fit to make, will be printed in the JOURNAL of the association, where every member throughout the State can read and consider its provisions. Having done that you can vote sagaciously, if you happen to be a member of the House of Delegates, or you can vote sensibly at the general meeting of the association if the plan shall be accepted by the House of Delegates.

Twenty-six States in this nation have adopted it. It has worked well in every one. It gains more cases for defending physicians than when they are defended by corporation lawyers. It produces expert attorneys who understand much more than the mere smattering of medicine and surgery provided by insurance attorneys for defendant physicians. The instances in which damages have been assessed are exceedingly few. The amounts assessed have been of the minimum sort, less than what many a physician has agreed to pay by compromising such suits, anywhere from \$50.00 to \$500.00. Last of all, not a single State once adopting medical defense has ever voted to drop it. Such facts offer invaluable testimony of the incalculable value of medical defense to the profession everywhere, and I hope to see it adopted in Maine.

Necrology.

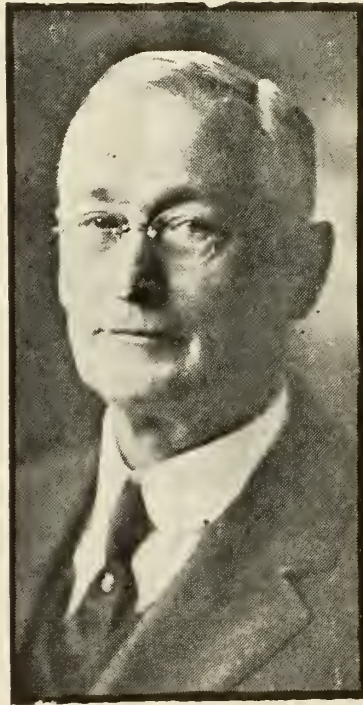
BENJAMIN FRANKLIN MAKEPEACE.

Farmington, 1860-1920.

Anybody looking at Dr. "Ben" Makepeace, as he was often called, would not take him so much for a hero as for a very shrewd practitioner of medicine, but if we only knew of the physical troubles through which he had passed successfully during his thirty years of medicine we would say that many men have been decorated for less heroism than his. A study of his adventures shows that he went through with two severe attacks of rheumatic fever, was operated upon at different times for gallstones and appendicitis, suffered long and tempestuously from asthma and pneumonia, and to cap the climax was thrown out of his carriage on rough country road and suffered ever after from a distorted spine. Other physicians may have met with greater physical misfortunes, but few of them, we are

ready to assert, carried them off so valiantly, and worked so successfully in practice to the very end of their lives.

Dr. Makepeace was the eleventh child of Alanson and Jane Gilson Makepeace and was born on a hillside farm in Carthage, Maine, February 8, 1860. His parents soon removed to Chesterville, and he was educated there and at Wilton Academy, and then taught school. As a youth he was born to command, and the difficult country school, with big boys and hoyden girls, was nothing to him; he could get the



better of them all. During school vacations he attended medical lectures at Bowdoin in 1884, and in 1887, in his 27th year, he obtained his degree at the University of New York Medical School. His thesis was based on a study of tuberculosis as likely to be modified in diagnosis and treatment by the recent discovery of the tuberculous bacillus occurring about that time.

He practiced first at Chesterville, one of his early cases being that of a prominent man suffering a serious injury of his right hand in a saw mill. Improvising a tourniquet, the young practitioner made good work with his instruments and saved a useful hand. This

good result helped him along wonderfully in the community and adjacent country. After practicing five years in Chesterville he moved to New Sharon, where he resided for eleven years, and from there he went to Farmington, where he labored for the remaining nineteen years of his active medical life.

Strong points in his character were his steady attendance on the meetings of the Franklin County Society, of which he was more than once President, and at the meetings of the Maine Medical Association, in which in 1905 he read a paper on "Diagnosis between Diphtheria and Pharyngitis." This was so well done that the discussion following it was the best of the meeting, and must have been very gratifying to the writer. For the county meetings he wrote on "Eclampsia" and "Pneumonia." He was a keen observer of his patients, skillful in emergencies, wanted always to be working and oftentimes observed symptoms which others had overlooked in their patients. His treatment was based largely on common sense, and as a man he lived and worked square with his associates. He made a success in the practice of medicine in spite of his asthma and other obstacles taking him off often from his practice for quite lengthy intervals of time.

It is pleasant to remember that, like other country physicians of whom it is said that they often snowshoed to their patients in winter, Dr. Makepeace during periods of strong icy crusts upon the snows of spring more than once slid from hilltop to hilltop in getting to and from his outlying cases.

After a severe attack of pneumonia he died February 16, 1920, a few days over the age of sixty, and after some thirty-five years in medicine. Our good faithful comrade in medicine rests from his labors. He is survived by his widow, formerly Miss Julia Edgecomb Foss, of Hollis, whom he had met as a teacher once in her native town, and by a son, also a member of our Association. His hearty handshake and his genial smile of welcome will be remembered at our meetings for many years to come.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

DOCTORS IN THE LEGISLATURE.

Ever since our government was established, physicians have served as Legislators. We find in studying the centennial of medicine in Maine that physicians from this State served in the General Court of the Commonwealth of Massachusetts, and that several of them have at various times represented Maine at Washington. There is much talk in these days, a century and more later, concerning physicians acting like public spirited men and going to the Legislature to see that laws for the benefit of the people are enacted and bad laws prohibited. This is a high ideal. Good citizens are always in demand. Unfortunately, however, for the scheme to get more physicians into the Legislature, few people ever think of the great sacrifices which every one of them makes in taking such a seat. A physician is himself. He tells his patients what to do in his own way. Nobody can tell them to do even the same thing in the same way, with the same authority or the same mental influence. No two physicians will give the same directions for apparently the same case. In other words, we repeat, that a physician is himself, so that if he leaves his practice for a seat in the Legislature he throws himself away from his patients, he abandons his local influence, he loses his income and it costs him more than he can regain.

If physicians are needed in the Legislature, why not insure their

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average income amongst the centers in which they practice, or in a corporation, or in this association itself! Who can tell but that sometime there will be a fund for loss of income for one physician in every biennial Senate and House. Truly it is expecting much, that physicians should sacrifice their incomes just to try to help out people who do not want to be helped out at all, or at all events, only in their own way.

Lawyers can attend Legislatures because they want to make the laws for their own benefit as all laws are made. Lawyers can try their cases at their leisure. They lose nothing by going to the Legislature. Merchants also can go and leave their business with partners and clerks and their incomes never cease. But the physician makes the greatest sacrifices of all, and should be, in some way to be devised, helped out for his income lost.

We would not, however, have physicians become politicians, because then they cease to be individuals. They become the common

property of schemers of every sort bent on their own advancement, and thinking only of big number one. Finally, we recall the little anecdote of the son of a prominent politician once calling out in a voice to be heard by everybody at a table of twenty loud-talking people: "As for my part, I don't see how a politician can be an honest man." From that point of view, which has its alternatives, we hope that physicians will never become politicians, but that as citizens they will from time to time continue to have simple ambitions to do their share in governing the State and making laws for the public health.

HEALTH INSURANCE UP TO DATE.

The London correspondent of the *New York Medical Record* places himself on record in this way, up to the date of February, 1920:

"Health insurance, as it concerns the profession, judged by test of two years before the war, is neither satisfactory to the panel practitioner nor to the insured. The abuses of contract practice have asserted themselves anew, and as many patients flock to certain practitioners, these men do not have the time to do their work properly, whilst other panel men are left out in the cold with nothing or but little to do. Objections are also continually arising in regard to the numerous and tiresome regulations and the insufficient pay. It is claimed also that the act is copied from Germany, but that its essence and principle are diametrically opposed to the genius of the English-speaking people for individuality and initiative. Health insurance in Germany before the war was far from a success, both as regards the results on patients and for medical men. If unsuccessful in bureaucratic Germany how can it ever become so amongst independent Britishers!

"More than all this, the independence of the physician is being gradually undermined, and the profession is powerless politically. In all probability the day will soon be here when the medical man will be simply the servant of the State and a preventer of disease rather than one who treats them. In the meantime Health Insurance is susceptible of many improvements both from the physician's and the patient's standpoint."

We trust that those men in Maine who have given any thought to the chances of health insurance, coming in to dwell amongst us will not fail to continue their studies, and to oppose to the bitter end its adoption without due consideration to their means of living as well as to the means of preventing and curing diseases by the profession.

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AMERICAN PUBLIC HEALTH ASSOCIATION TO CELEBRATE 50th ANNIVERSARY.

Next year the American Public Health Association will conduct its 50th annual meeting. An interesting circumstance is that Dr. Stephen Smith, the founder and first president of the association, will at that time be approaching his 99th birthday. Dr. Smith is still hale and hearty and possesses his faculties to a remarkable degree. It is his intention to read a paper at the meeting referred to. His vigor at a ripe old age exemplifies the results of sane living.

The American Public Health Association was founded at New York City in 1872. Until a few years ago it remained a strictly scientific body, somewhat on the order of the royal societies of Europe. More recently the membership has been broadened so that those may join who have a more general interest in public health, including such workers as health officers, laboratory men, school medical inspectors, industrial hygienists, public health nurses, physicians interested in preventive medicine, etc.

Dr. L. D. Bristol, Augusta, is chairman of the committee on membership for the State of Maine. Those interested in the objects of the association are invited to correspond with him.

Members of the association receive the *American Journal of Public Health* and the *A. P. H. A. News Letter* monthly, together with the customary association advantages. Dues are \$5.00 per year.

The American Public Health Association stands as an honored institution, which during the years has been tremendously influential in bringing the new methods of public health into use. Certainly no health worker can afford not to be a member, or to miss its publications.

A NEW BRAZILIAN MEDICAL JOURNAL.

We have received the first copy of a new *Journal of Medicine*, well printed in Portuguese, the daily language used in Brazil. The idea of starting it is that Porto Alegre, a place nearly as large as Portland, needs such a journal in order to keep up with the times. This magazine offers a long list of papers, amongst which we note those on "Intestinal Worms," "Renal Tuberculosis," "Forensic Medicine," and "Cerebellar Syphilis." It is a pleasure to be able to understand the language in which the papers are printed, because it shows us different types of diseases in Brazil in comparison with those most common amongst us.

Our thanks to the editors. Every new medical magazine with new thought and suggestion comes to the aid of humanity and brings physicians more closely together.


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Name.....

We note as a curiosity the advertising cards of all the specialists in Porto Alegre and also a picture of the handsome School of Medicine, a building three stories high, containing, in addition to the halls for the medical school, space for the Pasteur Institute, an anatomical museum, and laboratory rooms for chemistry, serology and technical work of all medical sorts.

A visit to South America would open the eyes of all of us to a great nation of which we here really have not the faintest idea.

HEALTH NEWS BULLETIN.

We have received and are grateful for the March Bulletin of the Department of Health. It contains a readable paper by Dr. Hitchcock on "Why Druggists Should Not Prescribe Proprietary Remedies Over Their Counters." When a man buys such medicines he is guessing at his health, and guessing as to his death. If he has used one medicine and thinks that he wants more, it is guesswork again. In every way the selling of proprietary medicines is a menace to health.

The other paper in the Bulletin is an account of York as a pioneer town in public health work, and gives in careful terms an account of what has been done in that flourishing watering place for the benefit of the residents and summer visitors.

MEDICAL DEFENSE.

After long study and deliberation, the Committee on Medical Defense are offering to the members of the association in the current number of the JOURNAL a paper by the chairman, showing in as compact a form as possible just what other States have done for medical defense, how it is worked out, and the results which have been obtained for its members everywhere when adopted and put in force. In order, moreover, that our members may understand additionally the paper as printed and the proposed plan for our association, and have an easier chance to look them over at their convenience, the JOURNAL is sending herewith enclosed a leaflet showing a tentative plan for consideration by county societies meeting previously to the State meeting in June, as well as for members of the House of Delegates at its yearly session. It is to be hoped that in this way a full understanding of the provisions of medical defense will be obtained so that every member of the county societies, as well as members of the House of Delegates and all present at the annual meeting, may be in a position to judge of the merits of the proposed plan and to vote accordingly.

This important topic has been before the association for several years. It has been postponed and again postponed, but the chairman of the committee now expresses to each member throughout the State the ardent hope that a final and favorable decision may be reached in June, in order that the prolonged labors and mental anxieties over the fate of medical defense for Maine, which has so undeniably proved its wonderful value wherever adopted, may be, at the June meeting of the association, positively decided and terminated for good and for all.

Notices.

MEETING OF MAINE MEDICAL ASSOCIATION, JUNE 15, 16.

Why not plan your vacation to include the above dates? Be on hand early and make this meeting a banner one in the history of this Association. Co-operate with the committees on program and arrangements, and bear in mind that the question of medical defense comes before you again this year for definite action. Other matters of importance to the physician and citizen will come up for discussion. Encourage your officers and committees by your presence, aid them with your counsel and so become an active member in your State Association.

MEDICAL INTERNE.

July 1, 1920.

The United States Civil Service Commission announces an open competitive examination for medical interne. Vacancies in Saint Elizabeths Hospital, Washington, D. C., at \$1,200 a year and maintenance, and vacancies in positions requiring similar qualifications, at this or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

Appointees whose services are satisfactory may be allowed the temporary increase granted by Congress of \$20 a month.

The positions are tenable for one year. During the year, however, a post-graduate course in mental and neurological diagnostic methods is given, an examination is held, and promotions to the next grade, junior assistant physician, are made. Beyond this there is regular advancement for employees whose services are satisfactory. Saint Elizabeths Hospital has over 3,000 patients and about 800 employees to care for. In addition to the general medical practice offered, the scientific opportunities in neurology and psychiatry are unsurpassed.

Both men and women, if qualified, may enter this examination.

Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Secretary of the United States Civil Service Board, Customhouse, Boston, Mass.

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PHYSICIAN.

May 5 and July 7, 1920.

The United States Civil Service Commission announces an open competitive examination for physician, on the above dates at the places listed hereon. Vacancies in the Panama Canal Service at the salaries indicated, and in positions requiring similar qualifications, at these or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

The entrance salary is \$200 a month; promotion may be made to \$225, \$250, \$275, \$300, and to higher rates for special positions.

Both men and women, if qualified, may enter this examination.

Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., or to the Secretary of the United States Civil Service Board at any place listed hereon. Applications should be properly executed, including the medical certificate, but excluding the county officer's certificate, and filed with the Commission at Washington, D. C., in time to arrange for the examination at the place selected by the applicant.

AT THE NEW ORLEANS MEETING.

Motion pictures showing the surgical uses of Dichloramine-T will be displayed at the April A. M. A. meeting at New Orleans, by The Abbott Laboratories, of Chicago. All physicians attending this meeting are cordially invited to see these and other interesting pictures of recent medical and surgical procedures.

NEW AND NON-OFFICIAL REMEDIES.

During March the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion in New and Non-official Remedies:

Abbott Laboratories:

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THE JOURNAL

OF



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VOL. X, No. 10.

MAY, 1920.

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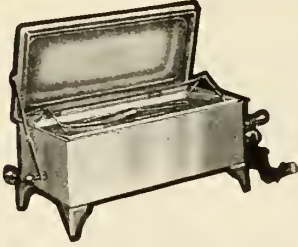
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Standard preparations of variable drugs, such as those mentioned, are made by increasing or decreasing the amount of raw material used in the manufacturing process.

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Methods of testing therapeutic agents are being devised and improved constantly in our scientific laboratory. Frequently there are no charted paths to follow—no established methods of determining the potency of drug products. In such cases we proceed to devise standards. A biological product for the control of hemorrhage was developed recently. How could the activity of the preparation be determined? And how could the product be adjusted to a uniform standard of activity? A physiological test was devised—a test which specifies that this hemostatic must shorten the coagulation time of the blood to at least one-third the normal for the test animal used.

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***A COMPARATIVE STUDY OF SERUM SICKNESS AND CERTAIN ACUTE EXANTHEMATA.**

By LEVERETT D. BRISTOL, M. D., DR. F. H., State Commissioner of Health, Augusta, Maine.

Serum sickness is a condition, now well recognized by the medical profession, which often results from the injection of horse serum or other foreign serum into man. In a hypersusceptible person the symptoms appear in about ten days after the injection. Edema, glandular enlargements, joint pains, albuminuria, fever and skin eruptions characterize the syndrome. In severe cases, congestion and swelling of the mucous membranes, cough, hoarseness, nausea and vomiting may also appear. The skin manifestations may be general or local in distribution, and in appearance may be erythematous, urticarial, morbilliform or scarlatiniform.

Many cases of serum sickness have been noted following the administration of diphtheria antitoxin. We now know, however, that the condition has nothing to do with the antitoxin itself, but that it is caused by the foreign proteins in the horse serum, and that even normal horse serum may bring about the same results in a hypersusceptible individual.

As a rule the symptoms appear, as noted above, about ten days after the injection, thus showing an incubation period analogous to that in some of the acute infectious diseases. This form of serum sickness is never serious or fatal. In exceptional cases the reaction

* Read at the meeting of the Waterville Clinical Society, November 20, 1919.

may be greatly accelerated, leading to unusual and fatal conditions (anaphylactic shock) within a few minutes of the injection.

Serum sickness is only one example of the condition known as anaphylaxis, or hypersusceptibility to various foreign proteins. These proteins need not be necessarily poisonous in themselves. For example, egg albumin, milk, extract of crystalline lens, vegetable proteins may serve to bring about anaphylactic symptoms when injected into susceptible individuals or animals.

Without taking time and space to go into details regarding the mechanism, symptoms, prevention or treatment of anaphylaxis in general or serum sickness in particular, let me confine my thoughts more specifically to the problem of bacterial anaphylaxis, for we are now well aware of the fact that even bacterial proteins may lead to hypersusceptibility and anaphylactic reactions. It has been experimentally demonstrated that even proteins from non-pathogenic bacteria may cause this anaphylactic state.

The tuberculous individual, his body sensitized with the protein of tubercle bacilli, is hypersusceptible to tuberculin, while the person free of tuberculous infection is not anaphylactic to tuberculin: hence the value of the tuberculin test. Likewise the person with glanders, his body affected by the protein material of *B. Mallei*, is hypersensitive to Mallein, while the normal individual is not.

Many investigators have shown experimentally that such animals as the guinea pig may be injected with the protein of any one of many bacteria, the first injection as a rule, giving rise to no untoward symptoms. But let such an animal be given a second injection of the same bacterial protein as used in the first injection, provided a definite period of time (usually not less than eight days) is allowed to elapse, and a typical anaphylactic reaction will appear in the animal. Following the recovery from such anaphylactic symptoms it is often found that a definite immunity or resistance has been induced, and subsequent injections of the same bacterial protein will cause no signs or symptoms in the animal.

From such facts we may assume that resistance or immunity to various bacterial diseases may be due in part to an original condition of hypersusceptibility. Furthermore, it is more and more evident that such an anaphylactic condition may be closely associated not only with the prevention or cure of various diseases, but also may be associated in certain instances with the causes of disease.

It is safe to say that for the physician, or health officer, there is no more important nor difficult problem than that which has to do with the group of diseases known as the acute exanthemata, including

measles, scarlet fever, German measles, smallpox and chickenpox. Probably the chief reason for our difficulty has been our ignorance with regard to the specific causal agents of these diseases. How significant it is to note the fact that among all the well-known communicable diseases we have fairly accurate and definite information as to the etiologic agents concerned, with the exception of the extraordinarily common group of diseases known as the acute exanthemata, characterized by various types of skin rashes.

When the time comes in which the microscope seems to fail us in the further search for a specific causal agent, should we not attempt to correlate the various facts that we already have at our disposal, and make intelligent use of them for the explanation of certain diseases that may depend on something *more* than a mere primary infection with a microorganism?

Concerning the nature of the disease agents which give rise to the acute exanthemata, Von Jürgensen¹ said: "Since the methods which serve for the demonstration of pathogenic microbes fail us here, we are justified in concluding that we have to deal with something of a different nature. We have no ground, however, for assuming that this different 'something' is not a living organism, since every argument favorable to a belief in a *contagium vivum* as the cause of infectious diseases in general applies in full force to the acute exanthemata."

Many years ago Jennerr² asked the question in regard to measles, scarlet fever, etc.: "May we not conceive that many contagious diseases, now prevalent among us, may owe their present appearance not to a simple but to a *compound* origin?"

I desire to present the hypothesis that scarlet fever and measles and possibly other acute exanthemata may have a compound origin, and may be due to varieties of bacterial anaphylaxis depending on various well-known microorganisms.

Bergé³ said, in regard to the cause of scarlet fever, "An imposing array of evidence points to the streptococcus in one of its virulent forms as the pathogenic agent of the disease." Time and further experimental work have served only to strengthen this belief in the minds of many investigators, although as yet the streptococcus as such has not been generally accepted as the sole etiological agent.

It is generally assumed that the chief portal of entry for the causative agent in scarlet fever is the upper respiratory tract, more particularly the throat and tonsils. However, the many apparently typical cases of scarlet fever developing shortly after childbirth, severe burns, wounds and surgical operations suggest the fact that the causa-

tive agent may also find extrafaucial portals of entry. For many years we have been aware of the relation between complicating streptococcus infection and childbirth, burns, wounds and surgical operations.

How may it be possible for the same microorganism to cause in some persons the typical symptoms of ordinary streptococcic puerperal septicemia, streptococcic wound infection and streptococcic sore throat, and in other persons a typical or atypical scarlet fever? What, after all, is the difference between a case of septic sore throat due to the streptococcus and a case of so-called scarlet fever? I would suggest that these various conditions may be due in part to differences in the susceptibilities of persons to streptococcus protein. Scarlet fever may possibly be described as a streptococcic anaphylaxis superimposed on a streptococcic sore throat, or on a streptococcic septicemia from some other portal of entry, in a person who has previously been made sensitive or hypersusceptible to streptococcus protein, either through the gastrointestinal tract or in some other way.

Furthermore, may we not possibly consider other acute exanthemata on a similar basis? The only difference may be in regard to the specific microorganisms and the portals of entry concerned in the sensitization and anaphylactic intoxication with bacterial proteins.

Measles may be nothing more than the manifestation of an anaphylactic intoxication following sensitization with protein of a well-known microorganism. In spite of the fact that measles is the most prevalent and widespread disease to which human flesh is heir, its cause has not been explained by finding or assuming any specific microbic or parasitic agent. Either the causal agent is one which is unrecognizable by our present methods of examination and diagnosis—a rather hopeless outlook—or else the cause is so simple in its explanation that we have overlooked it. Is it not suggestive that measles and pneumonia seem to closely coincide in number of cases, seasonal prevalence, mode of spread, communicability, etc.? May the pneumococcus in any way be associated with the cause of measles?

An account given by Duncan⁴ of an epidemic of measles and pneumonia at Camp Wheeler is most interesting in this connection. In point of time the measles curve and pneumonia curve almost coincide. There were 701 cases of pneumonia and 2,939 cases of measles. Of the 701 cases of pneumonia, 312 (44.51%) were preceded by measles, while 389 (55.49%) were not preceded by measles. 10.6% of the 2,939 measles cases developed pneumonia. Duncan says that "the two diseases occurred in different parts of the camp at about one and the same time, showing thereby that a common factor present at the same time in different parts of the camp had to be considered." The pneu-

mococcus as the etiological agent in both diseases, through protein hypersusceptibility on the one hand and through toxic action on the other, might explain many of the facts brought out.

From the standpoint of general factors such as annual, seasonal and monthly incidence curves, it may be said that measles and pneumonia correspond. Sporadic cases of each disease exist in nearly every community, and each may take on epidemic proportions. So far as geographical distribution is concerned, it is known that both diseases are widely spread throughout the world. In civil life as well as in army life pneumonia is now looked upon as a highly communicable disease, for which isolation and disinfection are as important as in cases of measles.

Susceptibility to both diseases and virulence of the causal agents in each disease seem to vary considerably from time to time. Both diseases have the same predisposing factors—crowding, poor ventilation, and the promiscuous spread of mouth and nose secretions.

Both measles and pneumonia are transmitted chiefly by direct contact, and the infectious agent of each has little vitality outside the body. Through the air zone of droplet infection due to coughing, sneezing, talking, laughing, etc., both diseases may be transmitted easily.

Before proceeding further it may be well to compare the symptoms and signs of measles with those of serum sickness which we have previously described.

Serum sickness and measles have about the same incubation period—an average of ten days. Both conditions are characterized by general malaise, fever, edema, lymphadenitis, frequently a temporary albuminuria, similar blood changes, skin eruptions, and they result in more or less protection against subsequent attacks. The eruption in serum sickness appears first around the site of injection and then spreads over the body. This eruption has a variable appearance often indistinguishable from a measles rash and may cause severe itching. The eruption in measles, following the appearance of Koplik spots in the mouth, spreads first over the skin of the face and head and then over the entire body.

It is noticeable that in serum sickness there is little or no evidence of the various inflammatory lesions in the conjunctivæ, nose, mouth and throat which are commonly found in measles. This may be interpreted by assuming that the possible anaphylaxis of measles is a natural one following the pneumococcic invasion of tissues of the conjunctivæ, nose, mouth or throat as portals of entry in persons hypersusceptible to pneumococcus protein, while serum anaphylaxis is artificially pro-

duced with its chief local signs around the site of injection of a foreign serum. On the other hand, congestion of the conjunctivæ and other membranes is frequently associated with serum disease.

There is nothing in the various experimental results obtained which is incompatible with the above explanation of the nature of measles. The few instances in which the inoculation of filtered or unfiltered blood, or mouth or nose secretions, from cases of measles to apparently normal individuals (or to monkeys) have resulted in transmitting the disease, may be explained by assuming the passive transference of a hypersensitive state (passive anaphylaxis) through blood serum, or the active carriage of the microorganism from one individual to another who has been previously sensitized to the protein of that particular organism.

A few years ago (1916) I carried on a brief investigation to test my original hypothesis as to the nature of measles. On account of other work, this investigation has been more or less interrupted until quite recently.

Realizing that the buccal mucous membrane is one of the earliest points of attack in measles, and that the characteristic lesions (Koplik spots) first appear on such membranes, it was decided to make a careful microscopic and cultural examination of these membranes in various stages of measles. Twenty-four sporadic cases of measles occurring in the city of Boston were studied, and form the basis of a preliminary report previously published. Sterile glass slides, swabs and tubes of media were used in each examination. The patient was placed in such a position and light that a good view of the buccal mucous membrane could be obtained. Using care not to touch the lips, tonsils or other parts of the mouth except the insides of the cheeks, sterile swabs were rubbed with considerable force over the mucous membrane. For each case three different swabs were used. The first was inoculated on the Löffler's blood serum, the second into glucose broth with a reaction of 0.3 to 0.5 acid to phenolphthalein, and the third was smeared over a sterile glass slide which was then fixed by heat. The cultures were incubated in an inside vest pocket until they could be placed in a laboratory incubator (usually within one-half hour). At the end of twenty-four hours, subcultures were made in various media, especially tall tubes of glucose agar (previously boiled to expel the air) and into tubes of ascitic fluid—kidney media with a layer of paraffin oil for the purpose of determining possible anaerobic organisms. Smears were stained by Gram's method and counterstained with safranin.

As a result of these preliminary tests it was found that all cul-

tures showed the presence of pneumococci. *Pneumococcus* was grown in pure culture from fifteen. From the remaining nine cases pneumococci, mixed with other pathogenic organisms, such as staphylococci, streptococci, and *micrococcus catarrhalis*, were cultivated. In the smears various mouth organisms were found, but in most cases the pneumococcus prevailed in largest numbers, especially within the phagocytic cells. No attempt at the time was made to differentiate between types of the pneumococcus, nor to determine the possibility that the organisms found might be considered as an additional type.

The predominance of the pneumococcus in many of the smears and cultures examined is certainly suggestive, and the additional finding of several pure cultures of pneumococcus adds strength to the opinion that the measles stomatitis in these cases may have been due to the action of this organism. The fact that pneumococci may frequently be found in the mouths and saliva of apparently normal individuals prevents any positive deduction in this regard.

Of more importance than the prevalence of pneumococci in the cultures from the buccal mucous membrane of cases of measles, was the finding in the smears examined of a very definite epithelial phagocytosis of pneumococci. If we are to give credence to our theories of positive chemotaxis, and believe that phagocytosis is an active defense of the body cells against attacks of bacteria, etc., we must assume that in the above instances the pneumococci were the invading hosts and that they were present in more than an incidental way. In these cases of measles the evidence apparently points to an active invasion of buccal mucous membranes by pneumococci, and an equally active defense on the part of the tissue cells against pneumococci. Koplik spots are apparently nothing more than heaped-up masses of buccal epithelial cells following an inflammatory reaction in the buccal mucous membranes, and in our experience these cells contained numerous pneumococci. In other words, my investigation revealed pneumococci as predominating microorganisms associated with the most characteristic diagnostic lesions of measles, namely the spots of Koplik.

The above ideas and findings have suggested to the writer certain experiments to determine the possibility of using simple anaphylactic skin tests for the diagnosis of measles and scarlet fever, if sufficient clinical material can be obtained conveniently.

The value of prophylactic streptococcus vaccines for the prevention of scarlet fever has been demonstrated by Gabritschewsky⁵ and other Russian workers, as well as by Watters⁶. Along this same line, experiments are planned by the writer to determine the possible value of prophylactic injections of pneumococcus vaccine to prevent measles.

In from ten to fifteen per cent. of persons who have been given the prophylactic streptococcus vaccine, a scarlatiniform eruption appears at the site of injection and often extends over the entire body. This may be associated with fever and all other symptoms of scarlet fever. Unless these are all coincidental cases of scarlet fever (an unwarranted assumption), it must be admitted that a syndrome resembling scarlet fever in man may be thus artificially produced in a hypersusceptible individual, and it constitutes a suggestive argument for the theory that scarlet fever is the result of a streptococcic anaphylaxis.

In recently published articles, Tunnicliff⁷ calls attention to observations on the bacteriology and immune reactions in measles, which are of much interest in the light of my own findings and hypothesis. Without suggesting that measles is in any sense an anaphylactic syndrome based on hypersusceptibility to pneumococcus protein, Tunnicliff has demonstrated the presence of Gram positive diplococci, resembling pneumococci, in the blood, sputum, throat, nose, eye, and ear from various cases of measles; the same diplococci were found in one or two cases in the lung, kidney, and bronchial lymph glands. Specific opsonins for these so-called "measles diplococci" were found to develop during the course of the disease. Agglutinins and complement fixing bodies were also demonstrated. No attempt to further classify this diplococcus was made.

I would suggest that measles and pneumococcal pneumonia may be nothing more than different manifestations of the same bacterial infection; in other words, that measles is a condition of pneumococcic anaphylaxis in a person hypersusceptible to pneumococcus protein, while pneumonia is the result of the localization of pneumococci and their toxic action in the lung, giving rise to inflammation and consolidation of the lung, and that these manifestations may appear together in one patient, as in a case of pneumonia following measles, or appear independently of each other.

As brought out in previous articles⁸ of mine, the possibilities that measles is nothing more than the manifestation of a pneumococcic anaphylaxis, and that scarlet fever is dependent on a streptococcic anaphylaxis may be worthy of careful consideration and further study.

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***CURRENT MISCONCEPTIONS REGARDING STATE HOSPITALS.**

By CARL J. HEDIN, M. D., Superintendent Bangor State Hospital.

In spite of the progress which science and civilization has made in the care and treatment of the insane, many superstitions and misconceptions regarding the insane and the State hospitals still exist. While time has eliminated such mistaken ideas as that insanity is a visitation of the gods or a demoniacal possession of its victims, who were put to death as witches or burned to the stake, there are still many who believe that the insane are kept in straight jackets to prevent violence, and confined in cages and prison cells.

The following are a few of the many questions that have recently been asked of our field worker concerning the Bangor State Hospital: "Are the patients abused, mistreated, and pounded?" "Do they put them into straight jackets?" "Do they get enough to eat?" "Do they have solitary confinement?" "Are they locked in cells?" "Are they mostly raving maniacs, jumping up and down, shrieking?" "Are the men and women kept together?" etc. Beside these rather common suspicions entertained by many people concerning the treatment of the insane, there are also those who still believe that insanity is a disgrace and that any person so afflicted is forever to be looked upon as a dangerous outcast from society.

The two most damaging misconceptions, therefore, still held by many intelligent people regarding State hospitals and the insane are that State hospitals for the insane are mad-houses where disorderly human beings are confined, bound and beaten, and that once a person is insane he is always insane. These mistaken ideas are unfortunate, for by them the impression is conveyed that the State hospitals for the insane are not hospitals at all for the care and treatment of disease, and that all mental disorder is unrecoverable.

HISTORY OF DEVELOPMENT OF STATE HOSPITALS.

Institution care of the insane dates back to 1403 in England, 1472 in Belgium, 1660 in France, and 1732 in America. The object of confinement of the insane before the nineteenth century was for safe keeping and was accomplished in ill-ventilated and inconvenient cells, or pens in the basements of hospitals and other places. This was the only care that the medical profession and the public at that time deemed

* Read before the Penobscot County Medical Association, January 21, 1920.

necessary for this most unfortunate class of human beings. In many states, the contract for the pauper insane was awarded annually to the lowest bidder.

The first State hospital for pauper insane in America was established at Worcester, Massachusetts, and opened in 1832. The next was in New York in 1843. In Maine the Augusta State Hospital was built in 1848. Adequate provision for the supervision of the insane, however, was not established at such an early date. The great majority were cared for at home, allowed to wander without restrictions, or were committed to almshouses and jails. The object of the State institutions was to care for the acute and recoverable class, and chronic cases being returned to the poor-houses when it was determined that no improvement was to be expected.

In 1890, the State of New York assumed full responsibility for the care and supervision of the insane, and the State of Maine assumed the responsibility for the support of all indigent insane in 1910. Though a few States still adhere to the system of county care, the great majority of the States now furnish State care for the insane.

While the development of State care for the insane showed steady progress in the erection of substantial and well organized buildings with modern methods of heating and ventilation, pleasantly situated, no pains were taken to study the personal comfort of patients. Airing courts were surrounded by high walls; patients who destroyed their clothing went without; those who destroyed bedding or refused to lie in bed slept on the floor; and those who were destructive were tied, handcuffed and otherwise restrained.

Although Pinel was accredited with the removal of the shackles and chains from the insane in 1792, mechanical restraint was extensively used until 1880. These methods were then believed to be absolutely essential in caring for the insane. The theory of treatment was to "overcome patients through fear, to break their wills," and to teach them that stronger wills than theirs were in authority. Gradually more humane methods of controlling excitement and violence were introduced, first in Canada, then in Michigan, New York, Massachusetts, and other States. Within the last twenty-five years, mechanical restraint has been almost entirely successfully replaced by hydrotherapy, industries, recreation and amusements.

METHODS OF EXAMINATION.

The reception of a mental patient to a State hospital does not differ essentially from the reception of a medical or surgical case at a general hospital. The patient is brought to the receiving ward,

where he is given a bath and put to bed. The pulse, temperature and respiration are then recorded and proper treatment of the patient begun.

THE HISTORY.

The most detailed obtainable history is then secured. Mental disorders at best are obscure phenomena, and in no field of medicine is a complete history of the patient more important than in the field of psychiatry. In securing the family history, it is equally important that we should get a record of all the normal members of the family as well as a history of the abnormal members. The patient's relation to hereditary tendencies can only be determined by securing information about his ancestors. The personal history of the patient is especially important for getting a comprehensive idea of the sort of person the patient was before the onset of the psychosis. Careful inquiry is therefore made into all the circumstances surrounding and conditioning the onset of the psychosis, and the patient's attitude toward them and his insight. All the contributing factors, medical and social, which have played a part in the breaking down of the mental faculties are considered. Here it is interesting to note that the causes of mental breakdown as given by the laity are largely social causes—poverty, hardship, worry, overwork, alcoholism, immorality, irregular habits, unfortunate love affairs, social maladjustments, etc.

As the conduct disorder resulting from the psychosis, and not the disease itself, is the cause for commitment to and confinement in a State hospital, it is of the utmost importance to have as fully as possible a clear conception of the individual before the onset of the psychosis, as well as a full understanding of the social factors which played a part in the breakdown, for all these factors play an important part in the future treatment of the patient. The knowledge of these factors, plus the medical findings, generally indicates the form of treatment that will aid the patient in social readjustment.

THE PHYSICAL EXAMINATION.

While the examination of mental patients is directed primarily to elucidating mental states, a complete physical examination of the patient is of utmost importance. Unless a physical examination in minute detail is made, the key to the psychosis may be overlooked. In each instance, therefore, the physical examination includes a description of the general type and appearance of the patient; the general nutrition is noted; the heart, lungs, and the abdominal organs are carefully examined; the genito-urinary examination includes exami-

nation of urine and a careful examination for venereal disease. The blood is also examined, and the spinal fluid, whenever such an examination is indicated. The neurological examination includes abnormal subjective sensations, abnormality in functioning of the special organs, abnormal cutaneous sensibility, disturbance of reflexes, disturbance of motor function, tremors and speech defects.

MENTAL EXAMINATION.

Careful observation of a patient begins when he is admitted to the State hospital. His behaviors, manners, facial expression, movements and positions, personal appearance and habits, are carefully noted. The general drifts and the nature of the mental state is observed. The patient's stream of thought and psychomotor reactions are studied. His orientation, memory, school and general knowledge are tested. His general mental attitude with reference to special moods, delusional and hallucinatory states are then studied, and finally the patient's insight and judgment are tested.

After the important and necessary features of the mental symptoms have been covered, the whole case, including the history, the physical examination, the laboratory findings and the result of the mental examination, are condensed into a concised summary, where the facts are noted in the order of their importance. This summary serves as a résumé of the most salient points leading to the diagnosis.

After a patient has been examined physically and mentally as already outlined, and observed for a period of from two to three weeks, he is presented in a staff meeting for diagnosis. Etiology, heredity, make-up, duration, treatment, and prognosis are subjects that are also discussed at the staff meetings.

TREATMENT.

In the treatment of mental patients the general principles of therapeutics are applicable as in other departments of medicine. The psychotic suffer from diseases of various organs as do the sane and require the same sort of treatment. There are conditions, however, met with among mental patients that require treatment, which conditions are rare or absent among the sane. Excitement, agitation and violence, for example, may occur in delirium of fever, but is of short duration—transitory—while in mental disease this condition may persist for weeks and months and require treatment.

HYDROTHERAPY.—Various forms of hydrotherapeutic devices form one of the more valuable means of treatment. The prolonged

bath is an important part of the treatment in certain cases of excitement. Patients are allowed to remain in the tub for hours, the water being kept at from 95° to 97° F. In many cases the continuous bath is the most reliable means at our disposal for quieting excitement. When the continuous bath is not available, or has failed in its object, the wet pack is usually resorted to. In this procedure the patient is first inclosed in a wet sheet, wrung out in hot or cold water, and then securely wrapped in a dry blanket. Hydrotherapy is now an accepted form of treatment in every properly equipped State hospital for the insane. The hot-air bath, the rain, fan, spray, jet, Scotch douche, and the sitz bath are all used. Massage and electrical treatment in some cases have also been found to be of some value.

Some of you are already familiar with the fact that our State hospital is well equipped, and has adequate facilities for the proper care of medical and surgical cases. Our operating room is modern and well equipped. The patients also have the benefit of consultations with surgeons, eye and other specialists. The services of a dentist is regularly employed.

THE DIET.

In the past, a great many State hospitals were run without dietitians. To-day every well organized State hospital employs a trained dietician. It has been well said that "A hospital kitchen without a dietician is like a locomotive without an engineer." There is plenty of food in one case and plenty of steam in the other, but the energy in them is wasted unless properly directed. Food represents calories, but should not be served as such. Economy, care in preparation—both as to quality and balance—and in serving are the important factors. The diets should be based on principles of nutrition, and so far as consistent on accepted habits of eating. A well trained dietician is now regularly employed at the Bangor State Hospital, and it is my opinion that our patients' diet compares favorably with the diet of the average taxpayer throughout the State. The fact that the great majority of our patients gain in weight after admission, even though they may not improve mentally, has led me to believe that our patients receive a better balanced and a more nutritious diet than the average citizen can afford to have in these times of high cost of living.

OCCUPATIONAL THERAPY.—Many of our patients are in good physical condition and show no evidence of physical disease. They are, therefore, fit to do a certain amount of work. The thing that prevents them from being useful is the fact that they cannot adapt themselves to the conditions that are before them. It is a part of our

treatment, therefore, not only to restore our patients to mental health as promptly as possible, but we must also return them to some useful occupation, or at least get them to take some active part in some simple task.

Even occupational therapy in its broadest sense, as work in the garden or on the farm, shows its effect on the patients simply because it gives them something to do. It shows them that it is possible for them to control and co-ordinate their movements and activities and make good use of mind and body in the production of results. While in some of them little in the way of permanent improvement can be expected, the majority show rather good effects. The type and kind of work are of little importance, nor is the output, either in quantity or quality, significant. The things that count, however, are the physical and psychological features that result from effort to overcome resistance.

The development in work therapy from that of simple tasks to craftsmanships that follows in the shops is sometimes surprising and interesting. Not only does the patient learn a more specialized kind of work, but frequently the shop becomes a place where he likes to be sent, and in its busy atmosphere of things being done he passes many hours during which he feels little of the burden which his condition would otherwise produce.

In a State hospital many types of work present themselves, not only as a therapeutic means, but because the hospital could not function without additional cost. Sewing, mending, ward work, kitchen and dining room work, etc., are largely done by the assistance of the patients. Farming, gardening, caring for the grounds, caring for stock, assisting in the boiler room, painting, etc., are accomplished with the assistance of patients' labor. The patients are told and a great many understand that they are doing these things for their own benefit. The therapeutic aim must be kept in the foreground, and the patient must realize that occupation is primarily a method of cure, and not a thing to which he can afford to be indifferent.

Sometimes occupational therapy is also a means of making the patient a better type of worker, a more efficient citizen, by teaching him a new trade or by training him to do things in a better way. Sometimes it is possible to add to his educational assets, to give him a broader outlook, to make him see the economic and industrial conflict in a broader light. The weekly amusements and recreations—dances, moving pictures, concerts, etc.—furnished our patients all have therapeutic as well as educational values. It also goes without saying that today all freedom possible is granted to mental patients. All who are not

suicidal, homicidal, or dangerous for other reasons, and who can be trusted not to leave the hospital premises are given parole of the grounds.

The policy of parolling patients into private homes under good normal conditions is encouraged. Frequently friends and relatives of our patients are used and requested to give the patient a trial at home. At the present time there are 125 patients out on parole from Bangor State Hospital. To be sure, many will be obliged to return for further treatment, but the important fact is that a large number of patients are at home and enjoying normal conditions who would otherwise have to remain in the hospital.

COMMUNITY SERVICE.

A community service department in connection with the State hospitals for the insane and the school for feeble-minded was authorized by the last Legislature. The duties of that department are in brief as follows: First, supervision and assistance of patients who have left the hospital; second, informing and advising people in reference to treatment and available institutions for indigent persons mentally afflicted; third, to examine and recommend suitable treatment for mental patients, nervous school children, and juvenile delinquents; fourth, to disseminate knowledge of mental disease, feeble-mindedness, epilepsy and allied conditions. In compliance with this law, the Bangor State Hospital employed a trained psychiatric field worker to take charge of this work, October 1, 1919, and I have recently been informed that the Augusta State Hospital and the School for Feeble-Minded are soon to follow in this line of work.

During the first three months, our field worker partially covered the territory included in the five eastern counties of the State. Her work consisted of taking family histories, visiting paroled patients, getting information in regard to financial condition of relatives of patients, making pre-parole inquiries, and disseminating information regarding the State hospitals and mental patients. She traveled 1,992 miles, interviewed 173 persons, described 361 persons, and charted 680 persons.

As already stated, the sole reason for the admission of patients to State hospitals is the disorderly conduct which renders them incapable of social existence. A paretic, for instance, is not sent to a State hospital because he has syphilis of the brain, but because his conduct either already has been, or is liable to become, such as to render him a menace to himself or others. The investigation of the environments, including the patient's home and relatives, his associates, his work and play,

is an important function of the State hospital field worker. Quite frequently the outside conditions are as much at fault as the patient himself, and more and more it is being recognized that social factors have a very definite bearing upon the causes, treatment, and prevention of mental disease.

After-care of patients is also a part of the function of the State hospitals. The release of the patient means a more or less abrupt transition which needs the most careful supervision if it is not to result in failure. It is necessary that the social worker who is to maintain this supervision be thoroughly familiar with the patient, his difficulties and disabilities. She must educate the relatives and others as to their attitude toward the patient, she must help to settle conflicts, prejudices or misunderstandings. These are all important factors for the successful return of the patient to a social existence outside of the hospital.

The social worker, therefore, is trained in the means for social adjustments; she collects information of social conditions prior to commitment; she gives advice calculated to relieve worry and apprehension on the part of the patient and the family; sometimes she assists the patient by finding suitable occupation and recreation, and she assists the patient by instructing him how to prevent actual breakdown.

In this connection I wish to say a word about a wholly preventable condition the responsibility of which appears to rest on some physicians. During the last twelve months, there were admitted to the Bangor State Hospital thirty-seven morphine habitues, and some of them were insane. Eighteen, or nearly 50%, of these cases gave a history of having acquired the habit from the administration of morphine by physicians. We all know that the morphine habit is a wholly preventable condition, and possibly, if the physicians were more careful as to whom and how they prescribed morphine, there would be less of this most wrecked class of patients.

LABORATORY EXAMINATIONS.

No doubt many of you present are already familiar with the good work that has been done in the past in our laboratory. The laboratory at the Bangor State Hospital is well equipped with all necessary modern apparatus, and is an up-to-date laboratory in every respect. I have been informed that our laboratory is considered the second best laboratory in the State of Maine, or second only to the State Laboratory at Augusta. I shall not say anything about the importance of a pathological laboratory. Certainly every physician admits that without any question. I will, therefore, present you with some of the work which has been instituted in the following routine manner:

URINALYSIS.—This is done for every patient admitted, and for other patients whenever the physicians in charge deem it necessary. Both qualitative and quantitative analysis is done, as well as microscopic examination of the sediment.

THE BLOOD.—The Wassermann reaction of blood serum is performed for every patient admitted, and those who show a positive reaction are given anti-syphilitic treatment.

SPINAL FLUID.—In every case that shows a positive Wassermann for the blood, spinal puncture is made and the spinal fluid is tested by the butyric acid test for globulin. Cell count, Wassermann, and the cold chloride tests are also performed.

ROUTINE TREATMENT FOR SYPHILIS.—Every case found positive for syphilis by laboratory examination or by clinical symptoms is given treatment. It should be stated, however, that usually the cases suffering from syphilis who are admitted to the State hospitals are either in the second or third stage; the majority of the cases are in the latter. Mercury, arsenic and arsphenamine are administered according to standard methods. Salvarsan is administered both intravenously and intermuscularly.

SPUTUM.—Routine examination of sputum is made for the bacteria of tuberculosis, pneumonia, influenza and other diseases caused by bacteria. Inoculation of guinea pigs is also done.

SMEARS.—Vaginal smears are taken from female patients admitted, and smears from the male urethra when indicated, and examined for gonococci. Smears from the nose and throat are also examined.

POST MORTEM EXAMINATIONS.—Autopsies are performed by the pathologist and attended with interest by the staff. During the last six months, or since my connection with the Bangor State Hospital, we have performed fourteen autopsies, this number comprising 36% of all the deaths during that period. No doubt you are aware of the fact that the great majority of the people are indifferent and even opposed to having post mortems performed. The public must be educated to the fact that post mortems are absolutely necessary for progress and research along scientific lines in medicine.

CONCLUSION.

In conclusion I may say that I have endeavored to show you that the State hospitals are not prisons, with cells and dungeons where the inmates are beaten and starved, as still believed by people who do not know the facts. I have shown you that Bangor State Hospital has ample facilities for the treatment of mental and nervous conditions,

for the clinical study of patients and for scientific investigation in a well-equipped laboratory. It is needless to say that we have an adequate staff of physicians, pathologist, trained nurses, and trained workers in every department, all of which helps to maintain a high standard of efficiency. To those of you who have never visited the Bangor State Hospital, and those who have not done so in recent years, I wish to extend a cordial invitation to visit the hospital. Come and see for yourselves how the hospital is managed, how the patients are treated, and come and visit our laboratory. Seeing is believing, and as a rule the surest way of correcting misconceptions.

***EARLY TUBERCULOSIS.**

By DR. OLIN S. PETTINGILL, Superintendent Western Maine Sanatorium, Hebron.

There is no disease which may offer so many difficulties in diagnosis as early pulmonary tuberculosis. You all know how helpless we are in treating the advanced cases, but no other disease may be so successfully treated in its early stages. Between these extremes the possibilities for success lessen as the disease progresses from the incipient to the advanced stage. With this progression the difficulties in diagnosis lessen as new signs and symptoms appear or become more pronounced. It is therefore apparent that the signs and symptoms which usually appear early in the disease are the ones for study and not the later manifestations, which, with their appearance, banish all hope for complete recovery in an almost direct ratio.

No matter how well informed or alert the physician may be in recognizing early cases there are many conditions which are not within his power to control. First: Many patients do not consult the physician until the disease is well advanced. The insidious cases do not notice their gradual failing health until perhaps confronted by the fact that they are unable to do certain things which they were accus-

* Read before the Oxford and Piscataquis Medical Societies.

tomed to do with ease. Other cases have an acute attack of pleurisy or hæmoptysis, and as soon as the acute symptoms subside they forget about it, aided by reassuring friends who tell them that it was due to a "cold" and that many healthy people have such attacks. Second: Patients do not consult the physician when they suspect the real nature of their trouble, being afraid that it may interfere with their pleasure or business, and, as is often the case, they take some advertised remedy, deferring the physician's advice until too late. Third: Patients in the early stages who are informed of their condition by a physician will not be convinced because of the lack of some conspicuous symptom, such as a cough, which they have seen in other cases, or, since they do not feel and look very sick, they consider it a waste of time and money to take the best treatment. These cases mentioned generally drift along until the disease becomes well established and the destruction of lung tissue is so extensive that when treatment is finally instituted it is only a "meditation on death".

Realizing that there is more literature published to-day in our medical journals concerning tuberculosis than any other disease, I know how uninteresting a paper on this subject must be to the general practitioner, but when we consider that the death rate in this State from tuberculosis was 926 last year, and the importance to the patient of an early diagnosis is so great, I feel justified in "boring" you to the extent of briefly emphasizing a few common facts which have been impressed upon me by my own daily observations and by physicians who have made a lifelong study of this disease.

A careful history of a case is of the utmost importance in making a diagnosis of any disease and it is especially true in recognizing early tuberculosis. It takes as much skill and patience to obtain an accurate history as to master some difficult manual technique. Of course it lacks the "brass band" features of some surgical displays, but often is as potent for good. I have heard several prominent specialists in tuberculosis say that if given their choice between making a careful physical examination and the opportunity of ascertaining the patient's history they would choose the latter. I do not wish to detract any from the importance of a careful physical examination, but this gives only the dose of tuberculosis the person is carrying. The history will interpret the physical signs showing how well and how long he has been carrying this dose. It is possible for the physical signs to be practically negative and yet pulmonary tuberculosis be present.

The family history is of value in showing prolonged exposure to infection. It will show also the family resistance to the disease. If other members of the family have died of consumption and the course

was one of gradual progression it frequently happens that this case will be of the same type. The so-called family tendency to tuberculosis or pretuberculous stage to my mind means that infection has taken place and lymphatic tuberculosis exists. The past history of the patient may show prolonged contact with the disease outside of the family. It is rare to obtain this history from the sanatorium patient. The occupation may be one which predisposes to lung disease or the past illnesses may show a susceptibility to infection.

In obtaining the history of the present illness it is well to inquire for all the subjective symptoms of tuberculosis. I will describe only the symptoms which in my observations appear early.

Foremost of the subjective symptoms I would place that so-called "tired feeling," with loss of strength. Nearly all cases give this history and in the majority of cases it appears first. Patients notice this in the morning on rising and the usual rest gives no relief. This tired feeling is not apt to be continuous in the non-progressive cases, for they have days of almost complete relief. These days of relief from symptoms are characteristic of tuberculosis and in the early stages are apt to be misleading. Loss of weight and the power of concentration of mental or physical effort frequently accompanies this condition. The loss of strength may be so gradual that patients can hardly date its beginning and only a careful inquiry will elicit these points.

Pleurisy or pleuritic pain is frequently an early symptom of tuberculosis. Nearly all moderately advanced cases give a history of some pleuritic irritation. The location of the pain is not axillary, as some text-books describe, but at first is more apt to be in other places. I have had patients tell of the presence of an occasional little "sticky" pain under the clavicle for years before other symptoms led them to consult a physician. This they knew was pleuritic from the character of the pain after the disease became fully developed. Pleurisy at the apex is frequently confused with rheumatic pain about the shoulder. Often the chest findings for pleuritic friction on examination at this time are negative, but this should not exclude pleurisy. Ninety per cent. of all pleurisies are tuberculous and pleurisy with effusion should always be considered tuberculous.

Cough with or without expectoration is not always an early conspicuous symptom. This is true in the pleuritic type of the disease. The cough, if present, is apt to be more troublesome in the morning or is brought on after exertion. This increase of cough may last several days after the exertion. "Colds" which last an unusually long time and are frequently repeated may be looked upon with suspicion.

So-called "colds" that begin with a cough are often only an increased activity of an existing lung disease.

The temperature should always be taken in every suspected case. The afternoon temperature should be most carefully studied and taken every three or four hours to determine any slight rise. The rectal temperature is more reliable, and it is such a delicate test that it will show a rise in the normal subject after physical exercise. This rise will drop to normal after thirty minutes' rest, but in the tuberculous it takes longer to reach the normal. A slight rise in temperature each afternoon is highly suggestive of consumption, but a normal temperature does not exclude the disease.

The pulse rate is often accelerated in the early stages. This may be in the morning and occur with a normal or subnormal temperature.

Hemorrhage from the lungs is always tuberculous or should be so considered even in the absence of any physical signs. Blood from the lungs is usually coughed up, but may come to the back of the throat without coughing. Extreme exertion or severe injury will not produce hæmoptysis in a normal lung. If pleurisy exists with hæmoptysis the diagnosis is positively established.

Digestive disturbances are varied and usually accompany pulmonary tuberculosis. They may mislead one to look for the underlying cause elsewhere.

Night sweats, bowel disturbances, rapid loss of weight and laryngeal involvement indicate advanced disease.

The physical signs of diseases of the lungs are familiar to all, but in their absence do not be sure that lung disease is absent. I will mention only four signs which I consider of the most value. Of all the procedures for detecting lung diseases, frequently proving our suspicions when all others fail, I should place auscultation of the cough. It is of more value than all others combined and is one with which any physician who is not specializing in this work can familiarize himself and be sure of his findings. To produce this sign the patient should be directed to exhale and then at the end of the exhalation to make a slight cough followed quickly by a deep inspiration. The rales, if any are present, may be heard at the beginning of inspiration and thus may be detected when no other means will elicit them. Rales should not be confused with muscle sounds which are heard during the muscular act of coughing. The supra-clavicular spaces or apices of the lungs and the margins of the lungs should be carefully tested in this way for rales.

Auscultation of the whispered voice is a delicate and accurate test for outlining the diseased area. Increased conduction of the whispered

voice is present over very small areas of infiltration and in consolidation it is marked. A cavity gives to the whispered voice sound a peculiar hollow note which is characteristic and its size can be accurately outlined. This sign is best shown by having the patient inhale fully and then whisper 99 or the letter A. It is of greatest value for the upper part of the chest.

Change in the breath sounds offer early evidence of lung disease, but their physiological variations are so great that the interpretation of slight changes is very difficult and many good observers differ widely in their deductions. The so-called "granular breathing" or "interrupted breathing" has been variously described by different authors. It is hard to define, as is shown by the variety of descriptions. The best way I can describe it is that the quality of the inspiratory sound is such that you expect to hear rales on the next breath but are not able to. I have observed this in favorable cases after the disappearance of rales and before their appearance in progressive cases. Broncho-vesicular breathing and prolonged expiration, if slight, is hard to determine. If it is more pronounced in the left apex than in the right one can feel sure it is pathological. Changes in breath sounds to be of any value must be limited to a definite area.

Percussion of the apices should always be practiced to determine infiltration of the apex or apical shrinkage. If I am sure that slight dullness exists here the stethoscope will verify it. We can often deceive ourselves with percussion and especially in fleshy subjects. Increased pitch of the percussion note which is described as diagnostic of beginning congestion has never been demonstrated to me, neither have I been able to find it myself. Percussion of the base of the lungs to determine the respiration excursion is of great value in diagnosing pleuritic adhesions and sometimes muscle spasm, both of which may limit the normal excursion.

The sputum, if any is present, should always be examined for tubercle bacilli. It costs nothing and bacilli will sometimes be found when not suspected. Absence of tubercle bacilli in the sputum should not exclude consumption. The tubercles on the alveoli of the lungs must begin to break down before bacilli can appear in the sputum. The expectoration before this may be due to bronchial catarrh in an effort of nature to reduce the hyperemia about the diseased focus. If one delays making a diagnosis until positive sputum is found he will have to be content with second stage cases.

Tuberculin as a diagnostic agent is limited in its usefulness. A positive skin test or Von Pirquet reaction indicates that tuberculous infection exists. Since nearly all adults have been infected at some

time in their lives it is of value only in children under five years of age. The conjunctiva reaction should never be used for fear of damage to the eye in susceptible subjects. The subcutaneous test with Koch's old tuberculin is of great value in doubtful cases. It should never be given until all other means of diagnosis fail. Unless properly given it is dangerous. If a reaction is obtained it proves the presence of tuberculous infection. If the reaction is accompanied by an increase of physical signs or localizing symptoms—a focal reaction—it is safe to conclude that the focus is in the lungs. Focal reactions occur in about twenty per cent. of subcutaneous tests.

The X-ray offers some aid to diagnosis of chest conditions, but here the interpretation of the findings must be done by a person thoroughly familiar with this line of work. From the plate alone it is impossible to tell whether the disease focus is active or not. In cases where a tuberculous infection exists without any definite localizing signs or symptoms the X-ray may offer valuable help.

After a diagnosis of consumption has been made the question of proper treatment arises. The best of treatment is none too satisfactory. Of the patients discharged from the Adirondack Cottage Sanatorium who have died, 95% of their deaths were due to consumption or some of its complications.

The sanatorium offers the best chance for recovery. This is not due to any superior knowledge of tuberculosis on the part of the physician in these places, but it is because in a well regulated institution a patient's condition can be more accurately studied and details of treatment insisted upon. Dr. Barnes, superintendent of the Rhode Island State Sanatorium, has shown in a recent report that over 50 per cent. of patients discharged from that sanatorium after taking treatment from six to nine months were alive after ten years from that time, compared with less than 25 per cent. of the same class of patients alive who took treatment less than a month. From these figures we find that a patient's chances for recovery are more than twice as good at a sanatorium as at home.

The earlier the treatment is instituted the better the results obtained. A summary last June of the 365 cases discharged from the Western Maine Sanatorium from Oct. 6, 1915, to Jan. 1, 1919, shows the following percentages of living patients, viz.: Incipient, 93%, with only one death, moderately advanced 69%, and far advanced 33%. Of this group 80% of the incipient cases are working, 49% of the moderately advanced and 16% of the far advanced are working. In other words, when a patient becomes moderately advanced he has

lost half his chances of again earning a living, and when far advanced, nearly all his chances.

Of all the agencies employed for treating active phthisis rest in bed in the open air is the greatest curative agent. The quieter any inflamed organ is kept the quicker it will heal. The same is true of the lungs, whether this inflammation is due to the tubercle bacillus or to the pneumococcus. Prolonged rest in bed until the case has become clinically inactive should be insisted upon. Physicians treating a case while waiting for admission to a sanatorium or during a relapse should insist upon plenty of rest. Exercise should be allowed at first only under strict supervision. I have never known too much rest to injure a case.

In conclusion, I wish to emphasize a few potent facts. Hæmoptysis is tuberculosis in 99% of all cases even in the presence of negative chest findings. Ninety per cent. of all pleurisies are tuberculous and when complicated with effusion should always be considered tuberculous. Do not wait for a positive sputum report before making a diagnosis. Auscultation of the cough is the most reliable means of demonstrating the presence of fine rales, and rales are always pathological. Prompt treatment of early cases offers the only chance for complete recovery. Before dismissing a suspicious case as non-tuberculous a careful history should be taken, a thorough physical examination should be made and if necessary every means which modern medicine has supplied us should be used to obtain a complete clinical picture.

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Editorial Comment.**MEDICAL DEFENSE.**

We take great pleasure in printing on page — of this issue a capital letter on medical defense from Dr. Jackson, of Houlton. It speaks for itself and shows that one man, at least, in the profession is anxious to get at some working plan for this important business. It seems to us that a committee of so many members as suggested in this valuable letter would be very difficult to get together. Without arguing one way or the other, we append at this point some very suggestive hints as to the working of medical defense in a State in which it has been in use for nearly twenty years with perfect success.

"It seems to me that you are wise in not having a committee on malpractice defense in your scheme. Our attorneys cannot wait often for action by a committee. You know as well as I that one man is generally the working member of a committee. A great many of our cases come to me at the last moment, *i. e.*, appearance in court is to be made on the first Monday of the month and that is next week. There is scant time to enter an appearance even. If a committee had to pass on these cases there would be no one to enter an appearance and the applicant for defense would be in contempt of court for not showing up at the appointed time. Your scheme follows the act of the Massachusetts Medical Society pretty closely. You add a post-mortem defense clause, I note. We have had one such case suggested, but no application was filed.

"We had one case of a Fellow who was a voluntary patient in an insane asylum asking for defense. The President and Secretary took it on, although the applicant could not sign the application, it being done by his brother. We thought we had power under the terms of the act. It was pure blackmail and under the law papers can be served upon voluntary patients though those who are committed are 'insane persons' in the eye of the law and cannot be sued.

"Practically all the malpractice defense work is now done in this office by telephone. In the past members came and sat with me by the hour together, taking up a lot of time. Now they telephone the chief facts in their cases, I send out copies of the act and application blanks and place the papers, when received, in my file. They tell the plaintiff attorney that they have applied for defense and in nine cases out of ten there is no further action; occasionally suit is entered, and in that event I fish out the papers and take up the case with the President, in accordance with the terms of the act. Now and then I have a visit from a member who expects free legal services for any old thing. Libel, a bill unjustly rendered, suits that do not involve malpractice are some of them. I get out a dictionary definition of malpractice, consult the President, generally by telephone, and turn down the application unless it is true malpractice. Sometimes a member will offer to pay the expenses of defense; once or twice a member has paid half. We have never taken up a special fund, though the idea appeals to me.

"I have obtained the services of the experts—we have them in almost every case. Men are always ready to serve and always without expense. Although we offer to pay traveling expenses no one has claimed this. At an annual meeting the society has voted its thanks to the fellows who have assisted in the defense. I try not to heap too much of this court work on any one member."

We are glad to present the opposite views of members and trust that every one will vote at the June meeting on the merits of the case. We can try it one year anyway and see how it works.

THE LATEST POINT FOR MEDICAL DEFENSE.

We take the following from the latest number of the *Boston Medical and Surgical Journal*, and emphasize it as a point of immense value for medical defense, which we hope the Association will adopt in June. It shows just what weight, in court, a united profession has.

"At a recent trial of a damage suit against a Boston physician, defended by the Massachusetts Medical Society, the judge made a decision important not only to the defendant but to all surgeons.

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He heard only the plaintiff’s side of the case, which included all the doctors who knew the case, as well as the defendant himself. At this stage of the case the judge said, in effect :

“‘All the doctors in this case agree as to facts and opinions. You therefore have no question as to facts to present to the jury. Such differences as there are in opinion are concerning surgical technique, and these matters are not for any lay jury to pass upon. I therefore close the case and direct the jury to bring a verdict for the defendant.’

“This decision indicates a line of defense against the present epidemic of suits against members of our profession. If the professional experts on both sides, in open, fair discussion of the case before the trial, find they honestly agree on certain facts, those facts at least and the agreement upon them can be brought out clearly at the trial. Such differences of opinion as are discovered, if found to be purely technical, will never reach a jury. A few such court decisions would

tend to discourage 'contingent' lawyers, would check the blackmailing class of plaintiffs, and would leave to be attacked only those surgeons who may not be giving due skill and ordinary care."

So far the JOURNAL, and in conclusion, we add that the Bar in Maine is thinking over some of the exhibits made in court by members of our Association, and trying to make it plain to them that obstructive differences between experts in Maine ought soon to be a thing of the past.

ADVANCE CENSUS REPORTS CHIEFLY FOR 1918.

The Department of Commerce has sent in a set of leaflets bearing on the principal causes of death during the past ten years as revealed by the present census. The total mortality for the year 1918, to which these leaflets chiefly refer, shows a rate of eighteen per thousand, which is the highest ever known in the country and is plainly attributable to the influenza epidemic of that year. Of the whole deaths 32% were due to that epidemic and to pneumonia resulting therefrom. The difference between the deaths in the last four months of 1917 and 1918 proves that the larger mortality in 1918 was due to no other cause than the epidemic as just stated. The next most important percentage of deaths was 27% due to cardiac, tuberculous, acute kidney and chronic kidney diseases with cancer. Organic heart cases were less than ever before, and the tuberculous death rate also lower. Kidney diseases also showed fewer deaths than usual. Deaths from cancer are steadily increasing, the disease being found mostly in the liver and stomach. Apoplexy is on the decrease, as well as diarrhoea and enteritis. Arterial tension deaths have declined, diabetes has held its own, bronchial and diphtheritic deaths are decidedly smaller than of old. Deaths from typhoid decreased 65% from the average of former years, which is supposed to be due to better sanitation and preventive vaccination. Whooping cough is higher and measles deaths lower than formerly. Accidental deaths, except from motor car accidents, have diminished decidedly. But seven thousand five hundred and twenty-five deaths from motor car travel is an appalling figure to contemplate! Nine out of ten of these are due to rapid driving and careless management of cars. It is plain that the nation should interfere in this holocaust of lives and compel a national examination of the ability of every driver of cars, trucks, or motor vehicles. Personally, we add that it is our belief that a very considerable number of motor car deaths are due to defective eyesight, to defective fields of vision, and to drivers with but one useful eye. Deaths from burns, drowning and asphyxiation are less than of old and suicides have taken a decided drop in percentage.

Those interested in statistics can study the appended tables.

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Correspondence.

HOULTON, MAINE, April 21, 1920.

DR. JAMES A. SPALDING,

Portland, Maine.

Dear Dr. Spalding:—In a recent JOURNAL of The Maine Medical Association you have enclosed a tentative plan that you will undoubtedly present for adoption at the June meeting of the Association. As I understand the plan, as proposed by you, the President and Secretary of The Maine Medical Association would constitute the committee having the power to authorize the attorney for the Association to defend a suit for alleged malpractice, if they saw the advisability of so doing, or to deny the request for defense on the contrary. It seems to me that such a plan is open to serious objection. It would hardly seem advisable, to me, to put such power and responsibility on two officers, one of whom is changed every year, for any decision that they must make would carry with it a very great responsibility. It certainly is advisable that the Association have a committee that will have the power to act in such cases, but it would seem to me advisable to have that committee made up of a man from each district, and that he should not be connected in an official capacity with the Association. With all due deference to the members of the Association who are not engaged actively in the practice of major surgery, it would also seem advisable to have the majority of the board composed of men active in that branch of the profession. The reason for such selection must become obvious on a little consideration. The average case of malpractice is brought for a breach of practice that deeply entails a surgical proposition. To pass upon the pros and cons of such a case requires a man actively engaged in such work. The President of the Maine Medical Association is many times not a surgeon but an internist or other special worker by training and choice.

Admitting the need for a committee,—and no one will deny it,—it would seem that a representative committee from the various districts would insure to the defendant and the plaintiff the best possible safeguarding of the rights of both parties. This committee should be given the power and right to go into all phases that is possible of the case, its judgment should be final as to whether the Association would or would not as a body defend the suit, and it also should have the

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power of bringing before the proper body for discipline physicians who have used unfair and unethical tactics and who have given opinions at gross variance with modern practice and teachings.

If the Maine Medical Association assumes the defense of members in malpractice suits, to gain the confidence of our bench and bar we must above all things show a spirit of undoubted fairness toward the litigant as well as towards members defending suits. It would be manifestly unfair and unjust if we ever assume an attitude of biased feelings and intent, and we would certainly defeat the result we now strive to obtain. The very minute that the Association shows that it is determined to act justly, with favor to no side, that it will defend a member whose case, after careful consideration by a representative committee is found to be just, but that it will not defend men whose work has been grossly negligent, then we will be able to do a very much needed work.

No surgeon would hesitate to lay before a body of men, whose ability and judgment he respects, the complete data of any case, and if such men are sued unjustly then we should certainly aid them in every possible way. The knowledge that a man would be defended by his State Association, that all cards would be placed upon the table, might

deter some "experts" from giving "opinions" that they now give, for they readily know that what is confusing to a lay jury would speedily be very apparent to a jury of physicians and surgeons.

This subject is of great import. It is to be sincerely hoped that some plan that will work for the best interests of all will be brought up, but we certainly need to approach this matter with careful thought. Malpractice suits are far too frequent.

Very truly yours,

F. H. JACKSON.

Notices.

REPORT OF COMMITTEE ON BOARD OF ORGANIZATION.

The idea of such a board is to form a permanent body within our Association for various purposes not provided for at present. Our President offers suggestions of value, so far as he has noted them in his term of office, but his term expires, and his ideas, also, and his successor goes through the same routine. The Council meets only on a call from the President, and it is too large to be called together more than once yearly. The House of Delegates has its annual meeting, but that, too, is even more unwieldy than the Council. We have therefore proposed, as borrowed from Dr. Marshall, of Spokane, Washington, a Board of Organization, and we suggest that it be composed of three members, one to be the retiring President, and the other two men of mentality to be chosen from separate counties for two and three years respectively. When one of these retires a new member from another county is to be elected. In this way the Association has a permanent Board of Organization.

Amongst the items of value to the State and to the profession which such a board might succeed in obtaining, we emphasize compulsory medical examination of school children, a national asset but shamefully neglected in Maine; extension of hospital work in the

shape of maternity wards to become an integral portion of every hospital in Maine; improvement of our present inefficient law for medical examiners, in the way of fewer men, and with it concentrated knowledge for post-mortem examinations; prevention of unwise legislation for the people; opposition to health insurance, and against the insidious legislation already stirring up against physicians in the idea of compulsory registration—a registration tax, a penalty for forgetfulness and removal from the list of practicing physicians for an entire year, and to cap the climax your photograph attached to your \$5.00 registration fee each year. In a word, we believe that a Board of Organization, with able men to keep it alive, could be of untold benefit to the Association.

We have invited our Maine delegate to the American Medical Association meeting at New Orleans to discuss the proposed board with the delegate from Washington, and others there present, and to bring us word at the June meeting of the Association. We therefore recommend that the idea of a Board of Organization be favored by the Cumberland County Society, and advanced for discussion into the House of Delegates.

JAMES A. SPALDING, Chairman,	} <i>Committee.</i>
STANLEY P. WARREN,	
E. W. GERHING,	

County News and Notes.

CUMBERLAND.

CUMBERLAND COUNTY MEDICAL ASSOCIATION.

The 53rd stated meeting of the Cumberland County Medical Association, was held April 9th, at 8.00 P. M., at the Congress Square Hotel.

The meeting was called to order with Dr. Francis J. Welch, President, in the chair.

There were present sixty members and three guests, Drs. Bartlett and Rowe, of Oxford County, and Dr. Hardy, of Kennebec County.

The records of the previous meeting were read and approved.

The Board of Censors reported favorably on the name of Dr. Mortimer Warren. It was then voted that the Secretary cast a ballot for the election to this Society of Dr. Mortimer Warren.

The following applicants for membership were received and referred to the Board of Censors: Dr. Wm. Everett Freeman, Dr. Jacob Melnick, Dr. Wm. C. Deixel.

Dr. Spalding, as chairman of the Board of Organization, pointed out the need of such a board to better meet the many problems constantly confronting the medical profession in this State. As suggested by Dr. Marshall, of Spokane, Wash., he favored a board of three members, one to be the retiring President of the Maine Medical Association, and the other two men of mentality to be chosen from separate counties for two to three years respectively. After a short discussion it was voted that this Society endorse the idea and that the committee be continued indefinitely.

A few remarks on medical defense were made by Dr. Spalding, who showed that such a plan in twenty-six States has practically eliminated malpractice suits. The chief objections made were: First, that the medical defense pays no damages, if awarded. Answer to this was that liability insurance can be continued for a while just as previously, and later an indemnity fund for all expenses of suits of malpractice can be raised by the State Association, as California already has done. Second, that expert testimony gets no fees under this plan. Answer to this was that under medical defense there is no need of expert testimony of one physician against another.

Dr. Spalding recommended that the Cumberland County Medical Society endorse the medical defense. This was discussed by many

members, and it was then voted that the matters of medical defense a reported by Dr. Spalding be referred, with our endorsement, to the House of Delegates at the next meeting of the Maine Medical Association.

Dr. Allen Krause's address on "The Historical Development of Our Ideas of Tuberculosis" was highly instructive and thoroughly appreciated by all present.

Following the discussion, participated in by many members, a rising vote of thanks was given to Dr. Krause.

Voted to adjourn. Adjourned.

E. E. HOLT, JR.

Secretary and Treasurer.

PORTLAND MEDICAL CLUB.

The regular monthly meeting of the Portland Medical Club was held on Thursday evening, May 6, at the Columbia Hotel.

Dr. A. W. White was elected to membership.

Drs. Weeks, Little and T. A. Foster were appointed as a committee to arrange for the annual field day in June.

Dr. M. Carroll Webber read the paper of the evening, "Differential Diagnosis in One Hundred Cases of Coma."

The following members were present: Drs. Gehring, Weeks, N. M. Marshall, S. P. Warren, M. Carroll Webber, Rogers, Swasey, Cragin, Connellan, E. O. Cummings, Swift, Dunn, Peters, W. Bean Moulton, L. L. Powell, B. D. Ridlon, Fisher, Patterson, Milliken, Haskell, Tibbetts, Everett, T. A. Foster, Haney, Thaxter, Little, Hatch, Carl Robinson, M. C. Webber, E. E. Holt, Jr., Sylvester, Spalding, Bickmore, P. P. Thompson, J. F. Thompson, Moore and Melnick.

SAGADAHOC.

SAGADAHOC COUNTY DAUGHTERS OF HYGEIA.

On April 24th, at the Bath Armory, the Daughters of Hygeia gave a dance and card party for the benefit of the Nurses' Home. The reception committee comprised Mr. and Mrs. William D. Sewall, Miss Janette Stannix, Mrs. Albert H. Shaw, Mrs. Charles P. Wetherbee and Mrs. Fred H. Kimball. Among the women who planned and had supervision of this fine party are Mrs. Warren Kershner, president of the club; Mrs. Clarence A. Peaslee, secretary; Mrs. Harry F. Morin, Mrs. E. Motley Fuller, Mrs. Seth S. Mullin, Mrs. Byron F. Barker. The party was very well attended and resulted in more than \$300 being cleared for the Home.

YORK.

YORK COUNTY MEDICAL SOCIETY.

The 100th quarterly meeting of the York County Medical Society was held in the Common Council rooms, in City Building, Biddeford, Thursday, April 22, Dr. F. W. Smith, of York Harbor, presiding.

The minutes of the January meeting were read and adopted.

Dr. Arthur J. Stimpson, of Kennebunk, reported an interesting case of gallstones that presented symptoms of malignant disease.

Miss Mary Van Zile, District Inspector of Red Cross work, spoke in an impressive and instructive manner concerning various Red Cross activities. A Red Cross nurse, Miss Wormwood, is rendering excellent services in Biddeford.

Dinner was enjoyed at Hotel Thacher from 1.00 to 2.00 o'clock.

The afternoon session was opened with an address by Dr. David E. Dolloff, of Biddeford, his subject being, "Some European Experiences." This address was a valuable one in many ways.

Dr. L. D. Bristol, Commissioner of the State Department of Health, was a guest of the Society, and his presentation of several important matters relative to a comparative study of serum sickness and certain acute exanthemata, also his instructive remarks with regard to the work carried on by the State Department of Health, were listened to most attentively and received with enthusiastic approval. On motion of Dr. Gordon, of Ogunquit, a rising vote of thanks was extended to Dr. Bristol.

There were present: L. D. Bristol, Augusta; F. W. Smith, York Harbor; J. W. Gordon, Ogunquit; A. J. Stimpson, Kennebunk; H. L. Prescott, Kennebunkport; B. F. Wentworth, Scarborough; C. J. Emery, M. H. Ferguson, E. D. O'Neill, C. F. Kendall, D. E. Dolloff, C. F. Traynor, Biddeford; J. D. Cochrane, J. D. Haley, F. C. Lord, C. G. Dennett, G. R. Love, Saco; J. A. Randall, A. L. Jones, Old Orchard.

Meeting adjourned at 4.00 P. M.

A. L. JONES, *Secretary*.

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—*Editor*.

NEW AND NON-OFFICIAL REMEDIES.

During April the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion in New and Non-official Remedies:

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Anesthesin—Abbott.

Aromatic Chlorazene Powder.

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JUNE, 1920.

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No. 11

AN OPERATION FOR THE CURE OF WEAK FOOT.

By HAROLD A. PINGREE, M. D., F. A. C. S., Portland, Maine.

The correction and maintenance of the longitudinal arches of the foot by means of tendino-plasty has been practiced by the writer for some years and appears to be a more rational form of treatment than the use of supports.

It is the purpose of this paper to present the details of an operation for weak foot, and to show the superiority of a particular method which has given successful results. The work here described is applicable only to a foot which is flexible and free from disease and its sequelae, which prevent normal movements of the bones.

The foot is provided with many joints, and when in normal condition its motion is free and restricted only by the muscles. The arches are four in number, an inner longitudinal, an outer longitudinal, and a transverse, all with their convexity upward; the fourth arch is horizontal with its convexity outward. In weak or flat foot the inner longitudinal and the horizontal arches are the important ones. Their summits are at the mid-tarsal section. In the act of weight-bearing the muscles relax, the arches flatten until brought up by the muscles and ligaments, and the foot becomes longer. In the act of walking the convexity of the arches increases, the foot is lifted by the muscles, grows shorter, and is raised in the step to be again placed upon the ground for the purpose of weight-bearing. This arch movement is repeated over and over again in the walking and standing positions.

The arches chiefly concerned in this condition are the inner longitudinal arch and the horizontal arch. All parts of the latter lie in a horizontal plane and the convexity points outward.

The principal muscles which control these arches are the *tibialis posterior* and the *tibialis anterior*. The *peronei*, from their origin upon the fibula and their attachment near the outer border of the foot, during their action, raise the outer border, increase the convexity of the outer longitudinal arch and evert the foot. They also depress the inner longitudinal arch and flatten the horizontal one. In this way the foot bends at the mid-tarsal joint and the front half is abducted from the midline of the body. In many cases the action of the peroneal muscles has been restricted by disease of the bones and joints, and they have become so short from habitual and continual deformity of the foot that it is useless to attempt the correction of the arches without first lengthening these tendons. It is evident that no deformity can be corrected without first removing all obstructions which maintain that deformity, or which prevent the structures of the part affected from assuming the normal extreme position diametrically opposed to the deformity.

In the condition of flexible flat foot the tendons of the tibial muscles are too long to do their part properly in maintaining the arches within their proper limits; that is, they are too long to help prevent the arches from sinking unduly, and they are not short enough to raise the arches to the necessary degree. There is too much "slack" in the tendons, and the muscles, after contracting to their limit, cannot increase the arches sufficiently or support them when in use.

Numerous methods have been used in the treatment of flat foot with varying degrees of success, and they have been modified to suit the individual case and the whims of the surgeon.

The usual mode of treatment has been the use of supports, such as plates to be worn in the shoes, and specially constructed shoes with reinforced shanks, raised heels and counters. Adhesive plaster straps applied to the foot and pads of different materials placed inside the shoe are other means of maintaining the arches in a more favorable position. These are passive supports to the foot and are in a strict sense only palliative. They do not in most cases effect a cure, do not, as a rule, cause so much discomfort as the condition for which they are prescribed, but usually give much relief.

Massage of the feet and legs and specially devised exercises for voluntary use by the patient are productive of much benefit and are theoretically more scientific. These are often used in conjunction with adhesive strapping, and in many slight cases such treatment is effectual.

The operative treatment, which seems preferable to all other methods in extreme cases, consists in lengthening those tendons which are short and which hold the foot everted and the arches flattened, and in shortening those which are too long to give the required support. This method presupposes a flexible foot, so far as disease is concerned, and aims to make the foot eventually self-supporting.

A glance at the anatomy involved will show that the peronei evert the foot and flatten the arches, that is, the inner longitudinal and the horizontal. The anterior tibial muscle raises the inner border of the foot, and in this way the arch. The posterior tibial, it will be seen, flexes the foot at its middle, so that the anterior half turns toward the midline and the inner border is raised at the same time that the outer border is lowered. The combined movement of the two muscles last named raises the arches and places the weight-bearing surface upon the heel, outer border and ball of the foot.

The principles involved in the operative method are as follows: All restrictions to complete adduction and inversion of the foot due to short peronei tendons and tendo Achillis must be removed. This allows the foot to assume its extreme physiological position of inversion, and the arches to increase to the normal limits. In order to maintain the arches, it is now necessary to shorten the tibials so that those muscles can pull to better advantage. By this shortening, the foot cannot, as before, relapse to such a degree of eversion.

After the usual preparation and under general anesthesia the foot is tested manually to see if full inversion of the foot is possible. If the normal is not obtainable the tendons of the peronei muscles are severed subcutaneously; if the foot then shows any restriction in flexion the heel-cord should be cut. An incision about four inches in length is now made over the anterior tibial muscle; the center of the cut should be over the point where the muscle and tendon join. After this part of the muscle and tendon has been isolated and freed from its surroundings the flat portion of the belly, where it fuses into the tendon, is cut diagonally across. The two ends are now overlapped and stitched together with 20-day chromic catgut (Fig. 1). The amount of overlapping to be made is a matter of judgment, and the operator must decide how much of the pronation, when weight is borne upon the foot, must be overcome. The muscle should be shortened sufficiently to firmly invert the foot. The fascia and skin are now closed. A similar operation is done on the posterior tibial muscle and the foot assumes a markedly supinated position with well defined arches. The foot and limb from toes to mid-thigh are now enveloped in plaster of Paris with the knee flexed at a right angle, the foot in a

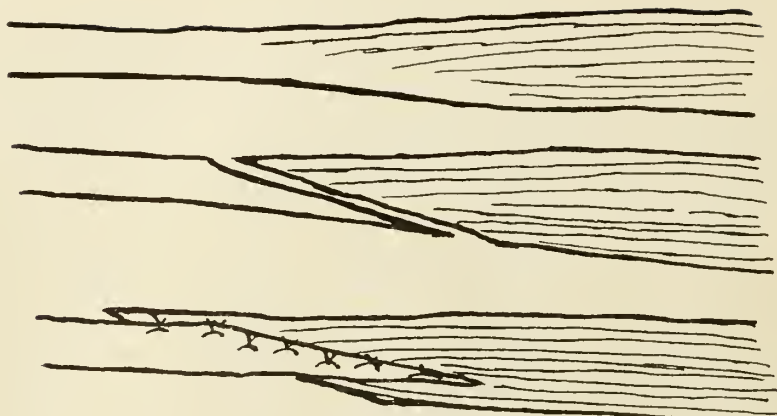


FIG. 1. Showing the manner of division and overlapping of the muscle and tendon.

position of exaggerated varus and the ankle sharply dorsi-flexed. After six weeks the plaster is removed and massage is commenced to restore the weak muscles. A support is necessary for the arch, and the patient is not allowed to bear any weight upon the foot until the plate is ready. He is now encouraged to walk, but the massage is continued until his ability to control the foot is well established. The plate is worn for a sufficient time to allow the muscles and their tendons to regain their original strength and action. It requires some experience to determine just how much the foot should be overcorrected. The following case will serve to illustrate this point.

Boy, aged 19. Extreme pronation of feet for years. Motion very limited, gait extremely awkward (Fig. 2). Operation on heel cord, peronei and tibials. Five weeks in plaster of Paris (Fig. 3). The patient was given metal supports and was instructed to walk and come to the clinic daily for massage and passive motion, but he disappeared for two years. When next seen he had worn the plates continuously without massage or exercise and had developed club-feet (Figs. 4 and 5). The result in this case simply shows that the feet were held in over-correction by the supports for too long a time, and, as the patient could walk more easily on the outside of the foot than he could on the sole, he continued to do so until the muscles became so short that it was impossible to place the foot flat on the ground. After the patient's return he was again admitted to the clinic and treated with massage and passive motion to correct the club-feet. Treatment was continued for a year with slight improvement, and finally tenotomy was advised to correct the deformity. This was

refused, however,* and at the present time the feet are strongly adducted.

Any stronger proof of the effectiveness of shortening the tibial tendons in extreme cases of pronated feet seems hardly necessary,



FIG 2. Showing the condition of feet before operation. The pronation of the feet and depression of the arches are noticeable.



FIG 3. The feet after operation and removal of the plaster. The elevation of the arches and the supination of the feet are evident.



FIG. 4. The feet in the weight-bearing position. The concave inner border may be clearly seen. The weight is carried upon the outer border of the sole.



FIG. 5. A rear view of the same foot as in Fig. 4. The inversion of the feet is plain.

as the result in this case was the establishment of persistent club-feet through neglect in the after-treatment. As already stated, care must be used not only in determining the amount of shortening necessary, but also in the after-treatment as well.

This operation is not advised in mild cases which yield to proper treatment in a reasonable length of time, but is advocated for cases of extreme deformity when other measures do not assure results which approach the normal.

***ADEQUATE PREPARATION FOR THE PRACTICE OF OTOLARYNGOLOGY.**

By GEORGE E. SHAMBAUGH, M. D., Chicago.

Abstracted by F. T. HILL, M. D., Waterville, Maine.

In a most comprehensive manner, Dr. Shambaugh discusses the above problem, which, though an old one, is most vital to the progress of medicine to-day. He commences his discussion with a report of four cases, as examples.

Case one was a patient in which the diagnosis was clearly otosclerosis. The man had been subjected to a septum, tonsil and adenoid operation, and both the middle and inferior turbinates on both sides had been removed, with resulting dry pharynx and crusty nose. These operations had been performed in an ill-advised effort to arrest the increasing deafness.

Case two was a man complaining of tinnitus. He was sent to Dr. Shambaugh with the recommendation that the septum, turbinates and tonsils be operated on. The nose, throat and ears were normal in appearance and there was no defect in hearing manifest. It is possible that the tinnitus was being caused by an incipient otosclerosis. At least there was no indication for these operations.

In the third case the hearing in the right ear was much reduced as a result of an exhausted suppurative otitis media. The hearing in the left ear was only slightly impaired and there was a slight discharge of mucus from a large perforation in the anterior portion of the drum, which had recurred from time to time. There was no odor. A radical mastoid operation on the left ear had been advised. In this case an operation was not indicated, as there was no sign of complications and this was the sole ear on which the patient had to rely for hearing.

Case four was suffering from a discharging ear, the result from acute otitis media, and showing signs of mastoiditis. Two days previous to consulting Dr. Shambaugh, he had been advised to have a septum operation and his tonsils and turbinates removed in order to cure his discharging ear.

The author asks the cause of this state of affairs and the remedy. The cause is the fact that the country is literally flooded with general practitioners who have found a lucrative field of work in doing operations on the nose and throat, but who have had no fundamental training in otolaryngology which has prepared them to make the proper

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examinations or to diagnosis conditions requiring these operations. To a great extent the fault lies with the city clinics and the so-called post-graduate schools, which cater to these men, coming with the sole object of learning the technique of a few operations on the nose and throat. These men have not been interested in learning the principles of otolaryngology. Diagnosis has not especially interested them. This state of affairs is to a great extent responsible for the existing conditions wherein wrong advice is so frequently given and so many unnecessary operations performed.

The remedy for this state of affairs lies with the placing of the study of otolaryngology upon a fundamental basis. Something more than the technique of a few operations should be taught. A physician preparing to practice otolaryngology should spend, as a minimum, one year of full time work in the fundamental study of this subject. This year's work should embrace the study of anatomy, embryology, physiology, and pathology. The reading should be directed and he should learn to make diagnoses and to understand the proper indications for operative treatment. The technique of these operations should be taught only as the final part of such preparation. Diagnosis is a difficult problem and the most essential. The poorly prepared "specialist", with his newly acquired technique of a few nose and throat operations, is a greater menace to the public to-day than when a few years ago he attempted to treat these cases simply by using sprays and topical applications, for no special harm was done by this treatment. In 1907 Dr. Shambaugh insisted that preparation for special practice should be as much in the fundamental sciences as in clinical study and advocated that this work be done in the laboratories of the university. He suggested that it be on the basis of a genuine graduate work leading to the granting by the university of a higher degree in otology. Dr. Shambaugh considers the specialties no place for the dilettant in medicine or for the unsuccessful general practitioner. The real specialist is the man who by perseverance and concentration places himself in touch with the most advanced line of work, where he is able to see and attack the various unsolved problems in his particular field. It is not so much the number of facts that the student is able to acquire in his preparation as the training to investigate these facts. And it is in this respect that the post-graduate schools in this country and abroad have failed in the preparation for special practice. Dr. Shambaugh believes that we are about to see the passing of the post-graduate school as an institution for training men for practicing the specialties and that the universities will soon take this up and place it on a rational fundamental basis. When this does take place otolaryngology will indeed have begun to come into its own.

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Editorial Comment.

MAINE MEDICAL ASSOCIATION.

*To the Delegates and Councilors of the Maine Medical Association
 and County Secretaries:*

The first meeting of the House of Delegates will be held at the Augusta House, on Monday evening, June 28th, at 8.00 o'clock. In so far as possible all the delegates will get together for supper before this meeting. Every society must be represented by its full quota of delegates. Each society is entitled to one delegate for every twenty-five members or major fraction thereof. Every society shall have at least one delegate. All the important business of the association is managed by the delegates and each component society should have full representation. This first meeting is by far the most important of the whole session, and this year especially matters of vital interest to every member of the association will be taken up. We want the chairman of every committee present and ready to report.

Dr. G. H. Coombs, chairman of the Legislation Committee, will have something interesting to report on medical licenses, medical examiners, liability compensations, and other matters which may come before the next Legislature. This committee was appointed by the last House and instructed to bring in plans for legislation to this meeting, where they can be discussed and as far as possible a complete

plan of action evolved for matters of medical interest in the coming Legislature.

Dr. Spalding will report for the Committee on Medical Defense. He has put an infinite amount of labor into this work and is now ready to report a workable plan for the Association.

Dr. Whittier, chairman of the Committee of Venereal Diseases, will report the activities of that committee for the past year. From him we always get an interesting and full report.

Dr. Miner is chairman of the important Committee on Hospitals. A number of the best medical schools have adopted or are about to adopt the plan of the fifth year of medical work for graduates, this last year to be spent as interns in suitable hospitals of sufficiently high standard. It is the work of this committee to co-operate with the aura in standardizing the hospitals of this State. The work is a very important one, and we hope for a full report from this committee.

Dr. H. E. Thompson is chairman of the Cancer Committee. This work is of increasing importance each year and is of interest to the whole profession.

This is the one hundredth anniversary of the Bowdoin Medical School. This year the Board of Overseers asked for a committee and report upon the advisability of continuing the school. All graduates of the school have received circular letters from different sources for and against. As the majority of our members are graduates of this school this should be of peculiar interest. President Sills and Dean Thayer have promised reports on present conditions and future prospects.

Dr. L. B. Hatch is chairman of the Committee of Public Health Among Women.

Dr. Spalding always has a full and interesting necrology report.

Reports of Councilors.—The Councilors have the oversight of all the county societies in their district. Part of the duties under the Constitution are as follows:

"Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of duties herein imposed shall

be allowed by the House of Delegates on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Association."

There will be two vacancies to be filled in the Council this year. The term of Dr. Barker, of the Third District, comprising Sagadahoc, also that of Dr. Turner, of the Fourth District, comprising Kennebec and Androscoggin, expire this year. It has been proposed that the Council be made a Board of Trustees and that it take a more active part in the work of the Association. The delegates from the societies comprising the Third and Fourth Districts should come interested as to their choice for Councilors and so advise the House of Delegates.

County Secretaries.—A great part of the success of a county society depends upon the activity of its secretary. It is of the greatest importance that he keep in touch with the plans of the State Association and keep his own Society informed. There should be at least two meetings a year together with the President and Secretary of the State Association, one in the early fall and the other at the annual meeting. Such a meeting will be planned at Augusta this year and notice will be sent to each secretary, urging him to attend, that plans may be considered for the coming year and the component societies be brought into closer association. I would rather strongly urge that the secretary in the future be made one of the delegates to the annual meeting.

Every member of the State Association should make a special effort to attend the meeting this year. The life of the Association depends upon the interest of the members. The Association should have enrolled in its membership every physician of standing in the State. It should be of greater assistance to the members and a greater power in State affairs. This can only be done through unselfish work and closer co-operation. We expect to have with us as a guest and speaker the active full-time secretary of the State of Pennsylvania. He will tell us many things about organization that will be interesting to know.

BERTRAM L. BRYANT,

Secretary.

WORKMEN'S COMPENSATION LAW AND LAW FOR MEDICAL EXAMINERS.

As members of the Association, we have received from the Legislative Committee a letter concerning the topics mentioned above, and from the State Department of Health another on the Venereal.

Referring to the first letter we consider it a good idea to have sent it out in advance of our meeting, for it is always brief, and most of

us have no idea what topics are to be considered and to be acted upon. Concerning this letter, then, we wish to say that there is in the Compensation Law much worthy of credit. The first-aid fee, as we have had experience with it, is satisfactory. After that comes the question of additional visits, and in this respect we believe that the corporations insuring should be treated fairly. We have, on the contrary, reason to believe that occasionally too many such visits have been made and charged, post mortem, as one might say. It might also be said that the operative fees allowed show a tendency to be cut down too low. There ought to be a spirit of give and take on both sides. Many workmen might throw over the law and get hospital care and operations at less than sums now asked by physicians. From that point of view the physician loses and the corporation saves. Some medium between a private fee and hospital costs might be used as a standard for operative fees under the law.

Another point of dispute is the choice of physicians. It seems often to an oculist, for example, that no contract physician should attend to the delicacies of eye injuries. To this it can be replied that all of these men have sense enough to know that if they take a risk that is greater than their skill they stand in danger of a suit. But most of them have invariably proved that they know when to call for a consultant in such instances. Free choice sounds well, but emergencies occur when there can be no such choice. Many workmen choose their own physician nowadays, and pay him, rather than come in under the law.

No matter how we look at it, many topics well worth deep study and consideration arise in looking into the Workmen's Compensation Law and we earnestly hope that all members will make some personal reply to the committee's letter, and additionally express their views publicly at the meeting at Augusta, in order that some beneficial decision can be attained.

As to the Medical Examiner's Law, it is too important to be considered in a single editorial annotation, for the law, in the end, involves the safeguarding of the lives of all the people of Maine.

How is it that in every famous trial, examiners are sent for from Massachusetts? There is one reason only; that they were men of skill when chosen, and that they are appointed again and again for their good work. Next, they are fewer in number than in Maine in proportion to the population. If you dilute knowledge by appointing five examiners, as in Cumberland County, with power for the Governor to appoint more if needed, you weaken it. One man making five post-mortem examinations in one year will learn more than five men making

one apiece. Whatever in our former law made for protection of the people has been reduced by multiplying our examiners.

We are positive that the system of paying men nothing at all, unless there happen to be murders, infanticides, and so on, in a given term of office is wrong. We are positive that no man should be appointed without being examined for fitness. We believe that the President of the Maine Medical Association should be consulted by the Governor in making appointments. We believe that men doing good work should be appointed again and again as a reward for their work, as is done everywhere else except in Maine. We are sure that one good man in every county is enough in these days of motor cars and the telephone.

Last of all, and here we open up an important point of view so far as our future medical examiners are concerned, we believe they should have more opportunities for obtaining the experience of making post-mortem examinations by compelling every hospital in Maine receiving State aid to have well appointed autopsy chambers and open them wide for examinations. We believe that if the people are taught that such an examination never means a visible mutilation of a body, they will not refuse, as at present, to discovering the causes of death, as a means of protection to those still alive.

J. A. S.

VENEREAL PRESCRIPTIONS.

The State Department of Health has sent out letters to physicians in Maine, asking them to co-operate with druggists in the treatment of the venereal disease by writing their prescriptions and sending the patients to the druggists instead of giving them the remedies personally. The idea has its justification on the ground that the druggist dispenses drugs for the purpose of making a living, to say nothing of guaranteeing pure products, and giving the patient what the prescriptions call for, without substitution. In ordinary diseases it is easy enough to understand why physicians ought to co-operate with the druggists, and that so far as the venereal is now concerned they should co-operate more zealously than ever before, because, as we understand the law, the druggist cannot now sell venereal treatment without a prescription.

In the treatment of this disease, however, the matter of privacy is involved more than in any other disease afflicting humanity. No person thus afflicted wants anybody else to know his trouble. If such a man consults a physician and gets from him the remedy, there is just one other person than himself who knows that he has the disease. But

if the physician writes a prescription and it is then handed to a druggist, the patient is open to the discovery of the druggist as well as to that of every employee. Then the patient is looked at as a syphilitic, not by the one man, the physician, but possibly by three or four. His condition is worse than that of women who, in the days of iodide of potassium, for instance, were made aware in drug shop of what was the matter with them from all of the clerks.

It seems to us that, until one person alone in a drug shop can alone have the means of knowing the patient's affliction, it is a vital question whether or no every physician is not justified in supplying his venereal patients with proper remedies. However, we hope by public discussion that some satisfactory conclusion will be reached, for it would be a sad day if the druggists, from inability to sell venereal treatment without prescriptions, should increase their counter prescribing for endless remedies in order to keep their pharmacal business alive.

J. A. S.

STATE DEPARTMENT OF HEALTH PAMPHLETS.

We are grateful for the arrival of three papers from the State Department of Health, ever active for community health and improvement in health conditions in Maine.

The first at hand is one on "The Diagnosis of Small-pox," which goes carefully over disputed points in diagnosis and makes the variations and difficulties clear to the anxious physician who may see so few cases of this disease nowadays as occasionally to be in doubt as to its actual presence.

The second bulletin concerns "The New Technique of Vaccination," a perusal of which will freshen the minds of all physicians to whom such opportunities come.

The third and most ambitious of the three papers goes carefully and minutely over "The Rules and Regulations Relating to the Communicable Diseases," and is a piece of medical literature well worth having ever ready at hand. Collected and classified up to the end of January, 1920, it will serve as a daily reminder, not only to the physician, but to public health inspectors, and others interested in public welfare in the State. We cannot commend too often or too earnestly to our readers the constant efforts of our State Department of Health in urging our people to do their utmost in every position in life to ensure the public health; in other words, to be of use to others, than to themselves alone, or to their own families.

VARICOSE VEINS.

Mention is made in a recent editorial in the *New York Medical Record* of a method of marking the skin with brilliant green, an anilin product, previous to the operation for varicose veins. From this the paper speaks of various operations for such veins, and emphasizes those known as the Mayo operation, and those of Schede, Trendelenburg, and others. Nothing, however, is said of the valuable method of Schiassi. This method was mentioned and the beautiful plates concerning it shown at a meeting of the Portland Medical Club at least four years ago, but it attracted so little notice from members present that we doubt if a single Schiassi has ever been tried hereabouts.

It is not for us to laud Schiassi as the greatest surgeon of the day, but certainly at his hospital in Bologna, he is doing remarkable work. A record, for instance, of 37 cases of partial thyroidectomy without a single death is good and commendable operative surgery. In the same line of thought, his operation for varicose veins is worth considering. In brief, a segment of a vein in the leg is separated from its continuity with the vein above and below, and into this portion is injected a solution of metallic iodine of the following formula: Metallic iodine, gram 1; potassium iodide, gram 110; water, 100 grams. Of this a maximum of about 50 c. c. is injected, the ends of the veins exposed are then ligated, as well as the small openings made down upon them. This watery solution of iodine has never produced an embolus—it cannot produce an embolus—and the X-ray pictures taken later on show satisfactory occlusion and obliteration of the venous walls.

To surgeons interested in trying what seems a valuable and safe method, we shall be pleased to show the original papers in French or Italian, and to translate them into fluent English, if so desired.

MINDING OUR OWN BUSINESS.

The *Oklahoma Medical Magazine*, under a title to the above effect, says that they have been asked a good many times if organized medicine should take any steps toward demanding prosecution of infractions of public health and medical laws. To this the editor replies that the State society has never done anything of the sort, believing that all such offences were merely violations of the common law and ought to be taken in hand by the State or local authorities. The medical society might stretch a point and go so far as to call the attention of officials to infringements of the laws as they interpreted them, but that the initiative for prosecution should invariably depend on the legal officials solely.

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In addition to this clear position for medical societies to hold attention is called to many instances in the past in which physicians urging the prosecution of offenders have been in turn accused of all sorts of ulterior motives except the real one, the protection of the public.

It is about time, as we judge from this annotation, as well as from others noticed elsewhere throughout the nation, to let the lawyers take care of the prosecution of offenders against the laws which they make at every legislative session, being in all such assemblages the large majority, doing to suit themselves, and making laws for their own ultimate benefit.

DUODENAL HEMORRHAGE FROM A SILK SUTURE.

The *Annals of Surgery*, page 682, prints a brief paper on recurrent hemorrhage in a patient who had been operated on some years before with every sign of permanent success for an ulcer of the duodenum. The ulcer was excised and the opening sutured with a purse string suture of black silk. Six months later some rectal hemorrhage ensued, at intervals, and in 1917 a second operation was performed for gastroenterostomy. In spite of it, hemorrhage recurred at intervals and the patient grew weaker and weaker. Finally, in the winter of 1919, the abdomen was explored again and nothing found at first, but finally in a fold of tissue a piece of black silk suture an inch and a half long was found. It was removed with ordinary forceps and the incision closed for the third time. Since then there have been no hemorrhages. The lesson from the case is that silk is a bad material for sutures in such localities.

THE STATE MEETING.

By this time the precessional notice of the state meeting should have reached all members, and those failing to receive same should immediately notify the Secretary.

Owing to unforeseen events, the date of the meeting had to be postponed to June 29 and 30, but a study of the programme will convince all fair-minded members that it was well worth while.

If you will study the Secretary's communication in this issue you will note that some very important matters will come up for discussion at this meeting, and whereas most of them will be presented first in the House of Delegates, those affecting the policy of the Association or offering radical changes will perhaps be re-submitted to the general session with such recommendations as the members of the House may see fit to make, so that it is important that there should be a large attendance. Why not make this a little vacation trip and see how well the Kennebec members entertain. A change of scenery, a cordial handshake with those brother practitioners from different parts of the State, a little more knowledge added to the vast amount we now have, and a sense of duty to our Association, will amply compensate us for any effort we may make. Let's go!

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Personal News and Notes.

Dr. Emmett L. Jones, a leading oculist and aurist of Cumberland, Maryland, was entertained at the Cumberland Club, Portland, Monday evening, June 7th, by Dr. James L. Spalding, and the following Portland members of the Eye and Ear Section of the Maine Medical Association were also his guests, Bowers, O. P. Smith, Little, Holt, Austin, Haskell, Moulton, Holt, Jr., Gilbert. After a well served dinner, conversation became general, and finally Dr. Jones spoke at some length on the curious fact that he had discovered various cardiac and gastric neuroses to yield to the exact fitting of the eyes to low grades of astigmatic lenses, with precise fixation of the axes. After the conclusion of Dr. Jones' interesting remarks, steps were taken toward the formation of an eye and ear magazine circulating club in the city, as a means of educational force in eye, ear, nose and throat practice.

Dr. L. Webster Fox, a prominent oculist from Philadelphia, was the guest of Dr. J. F. Hill, of Waterville, during the first week in June. On June 2nd, Dr. Fox held a surgical clinic, to which Dr. Hill invited the following ophthalmologists: H. T. Clough and Whitney, Bangor; Drs. Wakefield and Sullivan, Lewiston; Drs. Beech and Turner, Augusta; Dr. Kershner, Bath; Drs. Holt, Holt, Jr., and Gilbert, Portland. This clinic proved of great value to those present, as a variety of eye operations were performed in a very able manner. Following the clinic all present were guests of Dr. Hill at a dinner at the Belgrade House in the evening.

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—Editor.

Notes.

FRENCH MEDICAL NOTES.

The Laennec Committee, which had been hindered by the war in its plans for a centennial celebration of the discovery of the stethoscope, held a meeting in January to talk over plans suggested for a suitable memorial for Laennec. Amongst those suggested were a gold medal, a statue in Paris, a tuberculosis dispensary in Paris, a sanatorium, and a Laennec institute for the study and treatment of pulmonary diseases. Finally, a fund for poor medical students, such as Laennec was himself, was proposed. Nothing final was decided.

Referring to Laennec we have the pleasure of acknowledging the late receipt from France of a brochure in the Breton language, with illustrations showing the attitudes of King Grallon and Dr. Laennec at the famous consultation mentioned at the recent meeting of the Cumberland County Society. We regret that the sketches cannot be reproduced in the JOURNAL.

French savants are much displeased at the late award of the Nobel prize for chemistry to a German, because the invention for which the prize was awarded was antedated and invented much more advantageously for production by a French chemist, Claude. In fact, Haber, the winner, has borrowed freely from Claude, but produced less ammoniac and less transformation in bulk into nitric acid. The German makes 5%, the Frenchman 25%. Besides this, enormous quantities can be rapidly produced by Claude's methods, whilst that of his rival falls far behind. As the French writer says, Sweden had the chance to be disagreeable to France and to be servile to Germany, and she has not let the chance slip by.

Poison gas has been of late found to have a very constringing effect on gloves of kid, sometimes contracting them in a very few minutes into a third of their normal size when on the hand. This action on such material suggests the poisonous effects possible upon the tissues of the lungs and bronchial tubes, and explains the pulmonary effects of inhalation of the gas.

A study of people with six fingers, including the thumb, is progressing in France, and various instances of this curious sort have lately been reported in the journals. A family in Holland has been found, forty members of which are thus affected by inheritance. Spain also has brought forward an instance of a family of ten with six fingers, all of them, with the exception of the thumbs, being united with a web, like that of ducks and geese.

LIST OF DELEGATES TO AUGUSTA.

ANDROSCOGGIN.

A. W. Plummer, Lisbon Falls.
H. W. Garcelon, Lewiston.

AROSTOOK.

F. W. Mitchell, Houlton.
H. L. Dobson, Presque Isle.

CUMBERLAND.

C. M. Leighton, Portland.
C. H. Hunt, Portland.
F. Y. Gilbert, Portland.
F. N. Whittier, Brunswick.

FRANKLIN.

G. L. Pratt, Farmington.

HANCOCK.

C. C. Morrison, Jr., Bar Harbor.

KENNEBEC.

F. C. Tyson, Augusta.
T. E. Hardy, Waterville.
E. M. Boyer, Waterville.
R. D. Simons, Gardiner, alternate.

KNOX.

J. G. Hutchins, Camden.

OXFORD.

R. R. Tibbetts, Bethel.

PENOBSCOT.

C. M. Thomas, Brewer.
A. K. P. Smith, Bangor.
Edward Marquis, Old Town.

PISCATAQUIS.

Edgar T. Flint, Foxcroft.

SAGadahoc.

Robert C. Hannigen, Bath.

SOMERSET.

H. E. Marston, North Anson.

WALDO.

S. F. Fairchild, Searsport.

WASHINGTON.

O. F. Larsen, Machias.
E. H. Bennett, Lubec.
I. E. Dyas, Eastport, alternate.

YORK.

H. L. Prescott, Kennebunkport.
D. E. Dolloff, Biddeford.
C. W. Blagdon, Sanford.

Correspondence.

MAINE MEDICAL ASSOCIATION.

Dear Doctor:—This committee is desirous of having reports from every member of this Association upon what they consider are defects in the Workman's Compensation and Medical Examiner laws, in order that these views, with suggested remedies, may be made a basis for work before the Legislature at its next session, as well as for a report to the House of Delegates at the meeting in August.

This request is made at this time in order that it could ask for prompt work from every member if they have views and remedies on these laws, the time limit emphasizing the benefit of prompt work. Will you kindly write the chairman of the committee at once?

Medical licensure will be taken up in a paper by Dr. Leighton at the Augusta meeting.

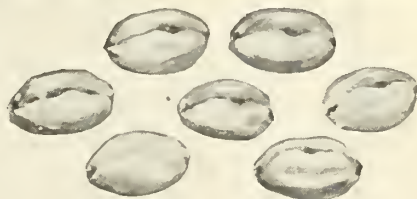
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***DEFECTS IN THE DRAFT IN MAINE.**

By C. B. SYLVESTER, M. D., Portland, Me.

The subject, which was not of my phrasing, appears limited to a discussion of the "Rejects" or "Defects" discovered by the examination of Maine draftees.

We would be derelict in our duty as advisors and guardians of the public health if we did not "carry on" for the benefit of the next generation all that we have learned in the last three years. There has been a great opportunity to find out the actual physical condition of our young men from 18 to 30. Nothing but a great and terrible war could have given us the chance to have every man undergo a physical examination. While a layman may speak in a trifling way about finding out "how many men were fit for cannon fodder," we know that the young men of our country have had a valuable inventory of physical assets and a physical education the like of which was never before possible. We have talked the need of a campaign for education in venereal diseases, and behold 4,000,000 young men have had instruction, direct and personal, and know the value of a clean life. We have heard of the need of temperance instruction and a demonstration of the advantage of actual prohibition, and behold the job is done—a lesson taught by war.

Our June graduates are talking from our school platforms of the hardy sons of New England and of the superiority of Maine men in

*Read before the sixty-eighth annual meeting of the Maine Medical Association.

mind and muscle. Beautiful—but is it true? The national report on education puts us 35th in the list of states and gives us a jolt. What can we—in whose hands it is to report—say of Maine's relative standing in physical efficiency? How do we compare with Kansas, with Alabama, with Oregon and Montana?

Education is the greatest factor in the cure of all public ills, but education is acquired in humiliation and not in conceit. We learn from failure and the sting of defeat, and profit by it. We now have a great opportunity to consider the after-war report from the Surgeon-General's office, and to learn from authoritative tabulations to see ourselves as "ithers see us."

The statistical information compiled from draft records showing the physical condition of the men registered and examined under the Selective Service Act was printed for the use of the Senate Committee on Military Affairs, and is a review of Bulletin No. 11, issued in March, 1919, and contains data on all men drafted prior to the signing of the armistice.

There were rejected by local boards 549,960 out of 2,753,922. The total number of defects were 468 per M, not counting duplicates. This means that, according to the standards set by the war department, nearly one-half of the men examined had defects requiring record, but not all of whom were refused. In the language of the report, "Fully half of the defects found are not of such a nature as to interfere seriously with services of the highest order in civil life."

Of total defects, 39% were mechanical, i. e., not necessarily due to disease, but a notable variation from normal, sufficient to interfere with the duties of a soldier; 12% were sense defects (three-fourths were of the eye and one-fourth of the ear); 11% were venereal and tuberculosis (to be exact, venereal 5.8%, and tuberculosis 5.4%); 10% were cardiovascular; 10% were defects of metabolism and development, such as over and under weight, defective chest development, hare-lip, goitre, etc.; 6% were nervous and mental (largely mental deficiency); 5% were nose and throat (hypertrophied tonsils, etc.); 3% were skin and teeth; 1% were respiratory diseases (other than tuberculosis); 3% all other. By states: Rhode Island led in total defect-rate, 802 per M; second, Vermont, 764 per M; third, Virginia, 734 per M; fourth, Oregon, 722 per M; fifth, Maine, 705 per M; Kansas, last, 422 per M. Actual number of men rejected: Rhode Island, first, 424 per M; Vermont, second, 354 per M; Maine, third, 346 per M; Wyoming, last, 128 per M.

The reproach to New England may be somewhat lessened by the

fact that the most critical standards were observed at Camp Devens and the three States here leading were given board examinations largely at Devens. There were seven-eighths as many total defects in the country as in the city. Numerically there was more flat foot than any other single defect, for one-eighth of the men examined had weak feet.

TUBERCULOSIS.

There were 80,601 total cases for the whole continental United States, 21,385 being plumonary. The ratio of the disease in city and country was as 100 to 78, this in spite of the fact that very many cases are sent from the city to the country for temporary and finally permanent residence, and also that this has been going on for at least a generation. If, with this handicap, the country population keeps its per cent. of tuberculosis down to 78% of the city, no better argument is needed to continue the practice of sending suspects and predispositions out of the city, *other considerations* being equal.

The ratio of incidence of pulmonary tuberculosis by States is as follows: Arizona, 63 per M; New Mexico, 60 per M; Colorado, 49 per M; California, 43 per M. These first four States are obviously resorts for tuberculosis, and for our purpose of equitable comparison we will rule them out, though the great State of California has so few tuberculous invaders in proportion to the total population that one might take exception to its exclusion. Rhode Island, 35 per M, really heads the list. It is the State of greatest density of mill operatives and has a large percentage of Irish, who are notably susceptible to tuberculosis. Connecticut is near the head of the list for somewhat similar reasons. Recent immigrants, who make up a large percentage of New England mill towns, and many of whom are "non-tuberculized", raise the tuberculosis rate. Maryland, 34 per M, has no reason assigned at the Surgeon General's office, which seems to us adequate. We are inclined to believe that a high per cent. of negroes in a maritime State nearly northern in temperature and conditions of life is the better explanation. Alaska, 29 per M, is unexplained, but it occurs to you all that life is maintained under restrictions from free air, and there is also a native population notoriously susceptible to infection by tuberculosis. Now we come to Maine, 28 per M. Why is Maine fourth? The reason intimated at the Surgeon General's office is that of being a health resort. The reason assigned in Rhode Island to Irish mill operatives is hardly tenable in Maine. It is something of a shock to find that we occupy so prominent a position in prevalence of tuberculosis, and we seek suggestions and explanations less humiliating than carelessness or ignorance or public neglect. Tuberculosis is relatively

high in maritime areas and Maine has a longer coast line than Maryland. It will be noted that the coast towns from Portland east give the highest per cent. of tuberculosis in Maine. Also there is a high per cent. of French Canadian population, which helps to raise the ratio in our mill towns. Following Maine are Kentucky and Tennessee, no reason assigned. We suggest that the natural healthfulness of the mountain sections is offset by the ignorance and insanitation of the mountain whites, while the negro population, like other near northern States, has a greater mortality than in the gulf States. Virginia has a high rate, 27.5 per M, due largely to the negro under similar conditions to Maryland. North Carolina, which is sufficiently a resort to give a high per cent, has 27 per M. The lowest rate is in the States of the northwest, Idaho and Utah, 13; North Dakota and Nebraska, 11; Montana and Wyoming, 10.

ASTHMA.

Maine second, with 133 cases; Vermont first. It is reported that "New England conditions are favorable to the development of asthma." Perhaps the writer knew what he meant by this statement, but we do not.

BRONCHITIS.

Maine, first, 63 cases; Rhode Island, second. This applies evidently to the more chronic cases and the report reads "as perhaps an idiosyncrasy of the examiners of this state." If cases were tabulated which should have been called tuberculosis it would only raise the already high tuberculosis rate. If bronchial asthma, it would raise the asthma rate.

DEFICIENT CHEST MEASUREMENT.

Maine first, New Hampshire, Vermont, Rhode Island, and Massachusetts follow. Credit is given at Washington for "greater care in measuring at Camp Devens," a sound reason which doubtless influences the high New England rate of other defects.

UNDERWEIGHT.

Maine, second; Rhode Island, first; Vermont, third.

OVERWEIGHT.

Maine, seventh; Rhode Island, first; and Massachusetts and Vermont follow.

TOTAL DEFECTS IN PHYSICAL DEVELOPMENT.

Maine, second; Rhode Island, first; Vermont, Massachusetts, and New Hampshire follow.

HEMORRHOIDS, VARICOCELE, AND VARICOSE VEINS, 290 CASES.

Maine, first; Alaska, Vermont, and Rhode Island follow.

HYDROCELE.

Maine, third; Nevada, first.

HERNIA.

Maine, 12th; Oregon, first.

CURVATURE OF SPINE.

Maine third. Doubtful in significance, but we find 165 cases. Probably a developmental fault.

VENEREAL DISEASES.

Here we can boast, for Maine is 44th in syphilis and chancroid, with Alabama first, and 37th in gonorrhea, with Florida first.

ALCOHOLISM.

In spite of the fact that all other northern New England States head the list, Maine is 21st, with Rhode Island first.

DRUG ADDICTION.

Maine is 33rd, with Delaware first. It has been claimed that because of prohibition in Maine there was an increased drug addiction in place of alcoholic stimulation. The figures seem to prove the statement untrue.

TOTAL VICE DISEASES, VENEREAL, ALCOHOLISM, AND DRUG ADDICTION.

Maine 41st.

GOITRE.

Total, Maine 42d, with 17 cases; simple goitre, 39th, with 13 cases. The States of the Northwest have a very high rate, Idaho and Oregon, 27 per M; Washington, Montana, Utah, Wyoming, Wisconsin, Alaska, and North Dakota following closely, while Maine is two-thirds of one per M. The most of this is reported in the eastern section of the State in spite of our previously considered frequency in Oxford County.

DIABETES.

Maine fifth, but only 11 cases are reported, which weakens the value of the report.

OBESITY.

Maine second, with Rhode Island first. Number of cases, 74. Explained in racial reports as due to French inhabitants, hence in Maine the western section containing the mill towns has the highest per cent.

SPEECH DEFECTS.

Maine first with 46 cases. Maryland, Kentucky, Virginia, and Vermont follow. The highest per cent. is in the western section of the State and throughout the country the rate is higher in agricultural groups.

HEARING DEFECTS.

Maine first, with 239 cases; Connecticut and Vermont next. Highest per cent. in the eastern section.

DEAFNESS.

Maine second, with 56 cases; Vermont first. Highest rate in the eastern section of the State. Sixteen cases of deaf mutism added to above makes Maine's total 311.

OTITIS MEDIA.

Maine third, with 262 cases. The reasons assigned for the high per cent. above are, first, the low relativity of otitis media among negroes, which lowers the rate in all Southern and border States; second, hereditary tendency in old New England families, with intermarriage of deaf mutes; third, a less apparent reason of early immigration to New England from South Eastern Europe.

DEFECTIVE TEETH.

Maine fifth, Vermont first. New Hampshire, Massachusetts, and Rhode Island follow.

MYOPIA, DEFECTIVE VISION AND BLINDNESS.

Maine fifth, with 1,310 cases, Rhode Island first, with Connecticut, Massachusetts, and Vermont following. There were 133 cases of eye enucleation and total blindness in Maine. The maritime section of the State had the lowest per cent. of defective vision as well as defective hearing. Refraction errors appear to be more common in the western section.

EPILEPSY.

Maine eighth; Vermont first; Maryland, New Hampshire, Connecticut, and Rhode Island in the lead.

CHOREA.

Maine third; Vermont first.

HYSTERIA.

Maine third; Vermont first.

NEUROSIS AND NEURASTHENIA.

Maine sixth, with 12 cases.

TOTAL OF COMBINED NEUROSES.

Maine seventh.

MENTAL DEFECTS.

Maine second; Vermont first; 508 cases in Maine.

MENTAL ALIENATION.

Maine third; Vermont first; 566 cases in Maine.

PSYCHOSES AND GENERAL PARALYSIS OF INSANE.

Maine ninth; Vermont first; 40 cases in Maine. Epilepsy is named as high in the eastern section of Maine. The psychoses and alienation are high in the maritime section. "In-Breeding" is referred to as common in this coast section and is judged causative of psychoses as well as deaf-mutism. Popular writers have referred to the enforced loneliness of so many homes by the sea as a reason for insanity among the women of the State. Epilepsy and deaf-mutism are highest in rating in the agricultural group of occupational diseases and in the maritime of geographical sections, hence a combination of causes, among which the French racial admixture is very material.

NEPHRITIS.

Maine eighth; Connecticut first; but only 23 cases.

MYOCARDITIS.

Maine first, with 325 cases; Vermont second.

ENDO-CARDITIS AND VALVULAR DISEASE OF HEART.

Maine tenth, with 111 cases; Washington first.

CARDIAC HYPERTROPHY AND DILATATION.

Maine second, with 182 cases; Nevada first.

TOTAL CARDIAC ORGANIC DISEASES.

Maine second, Washington first.

ARTERIO-SCLEROSIS, ARYTHMIA AND TACHYCARDIA.

The rate for Maine is respectively .45, 1.96, and 6.05 per M. No especial significance, as the number is small.

ARTHRITIS AND ANKYLOSIS.

Maine third, with 299 cases; Alaska first. "Exposure to infection" in extreme temperature is inferred, and the southern States come near the head of the list, due to gonococcus infection among negroes. No mention is made of tuberculosis, which is also a most likely cause in Maine and Alaska. Ankylosis has its maximum rate in Maine, together with Alaska and Oregon. The rural rate is 5.7 per M, attributed to the lumber industry. Section 1 has 5.6 per M, and section 3, 6.9, while urban Maine has the extreme rate, 8.9 per M, due solely to Portland, as it was the only city reported. The prevalence in Portland is unexplained.

GEOGRAPHICAL DIVISIONS OF MAINE.

Section 1, called the eastern section, includes Aroostook, Penobscot, Piscataquis, and Washington counties.

Section 2, called the maritime section, includes Hancock, Knox, Lincoln, Sagadahoc, and Waldo.

Section 3, called the western section, includes Androscoggin, Cumberland, Franklin, Kennebec, Oxford, Somerset and York.

RACIAL DIVISION, GROUP 19.

(French Canadian ten per cent.)

Maine is actually 12½% French. The colored population of Maine is one-fifth of 1%, and therefore negligible. The Irish are only 3½%, and the total foreign born population is 11%. To quote from the Surgeon General's report: "On the whole, the French Canadian group, by virtue of a high per cent. of tuberculosis, pleurisy, nervous and mental defects, defective eyesight, otitis media, defective hearing, valvular functional heart disorders, bad teeth, defective appendages, and small size, constitutes perhaps the poorest of the groups, from a military point of view." Their venereal rate, to their credit, is some-

what below normal. This applies to syphilis and chancroid evidently, as the total rate is given as one-half the average, yet gonorrhoea is named as "abnormally common."

URBAN AND SUBURBAN DIVISION.

Significant differences are as follows: Alcoholism is a positively urban disease. Boston has the highest rate, with the Rhode Island cities and Chicago next. Drug addiction is also an urban characteristic, with New York highest. Obesity is plainly urban at the ratio 3 to 2. Chorea and neurasthenia are commonest in cities, although neurasthenia is especially frequent among negroes. Boston has the highest rate for neurasthenia, epilepsy and other neuroses. Flatfoot is also more frequent in cities.

Defects of speech were more common in the country than in the city. Hysteria and epilepsy also carry a characteristically higher rural rate, with the observation that "rural inbreeding among the whites" is more or less responsible. Venereal diseases are slightly greater in number in the country. The same is true of arthritis and muscular rheumatism. Asthma is in the same class, while mental deficiency is almost twice as common in the country as in the city. The "commuter" or suburban group has the lowest percentage of venereal disease, and otherwise boasts freedom from physical defects.

OCCUPATIONAL DIVISIONS.

The eastern manufacturing group has the highest rate of physical and mental defects and of tuberculosis. This is due not merely to manufacturing conditions, and mutilations, but also to racial differences among immigrant operatives, such as defective vision of Polish Jews. The lowest ratio of total defects is in the mining group, which has the highest rate in deformities and mutilations from accident, but the lowest rate in tuberculosis and most other diseases except syphilis, which is high. It is entirely contrary to preconceived opinion that tuberculosis should have its lowest group rate among the miners, where ventilation has been reputed to be poor, to say nothing of anthracosis, which was formerly thought to be a causative factor. In regard to the latter, it is a personal observation from autopsies of the tuberculous and of miners, as well as practice in the coal country, that coal dust is merely a mechanical obstruction in respiration when accumulated, and is not provocative of infection. In the interest of accuracy it should be stated that the coal miners of western Pennsylvania were examined at Camp Sherman, where it is noted they were slow to recognize, or at least record, defects.

The southern agricultural group has twice the percentage of venereal diseases over the northern agricultural group. "The defect rate of the mountain whites is 71 per M, contrasted with 51 per M that of the native white farmers of the south." There is more tuberculosis in the southern than the northern group. It is very surprising that there is ten per cent. more tuberculosis among native whites than negroes. It may be that the medical examiners in negro sections were inferior to those of native white sections. Or, the course of pulmonary tuberculosis being more rapid among negroes than whites, there would thus be a less percentage of *chronic* tuberculosis among recruits. Morbidity statistics of the Census Bureau give the death rate from tuberculosis 176 per M for negro, and 98 for whites. Thus a contradiction appears, with the *death* rate higher in negroes and the *morbidity* rate less, which may be explained by a briefer period of illness before death. The Surgeon General's report for 1918 gives three times as many admissions to sick report for tuberculosis among negroes as compared with whites. There is a discussion of the relative infectivity and resistance among mulattoes and full blooded blacks, a question which has some bearing on these statistical reports. It may be that the hitherto believed greater morbidity among mulattoes is due to their association with whites, rather than admixture of white blood, as would be well shown in the high rate of Kentucky, Maryland, Virginia, and Tennessee, while Mississippi, Georgia, Alabama, and Florida are lower. Then, too, it is considered well known that the more northern climate increases the morbidity of the negro in respiratory diseases, due perhaps to heedlessness and lack of adaptation in clothing and habits.

This, among many questions, some of which concern our own State more closely, has now a chance for a more intelligent answer than ever before, by reason of what we learn from these war figures. This advance in the knowledge of our efficiency and deficiency must be kept up by repeated future examinations, not merely that the government may have a roster of arms-bearing men, but for the protection and conservation of the men themselves. If, with the progress of agriculture, scientific breeding is a necessity, how much more important in the progress of our race is the breeding of men, which study would require an inventory for a basis, and an inventory repeated for a progress index. Is it too much to ask that young women of child-bearing age—certainly as necessary as arms-bearing men—may be included in the stock-taking of the future?

The problems of industrial life, now to the front, i. e., wage earning, child welfare compensation in sickness, accident and old age,

require for intelligent consideration a knowledge of the physical and mental normality in differing environments and conditions of sanitation, and of medical supervision in different parts of the country, with the variance in social, racial, and industrial organization, city and country, North and South, East and West. That nation or that race will lead who studies its development, physically, mentally, and industrially, and corrects developmental faults. A measure of its progress can be had by exact medical examination, through some adaptation of a plan of universal training, prejudicially called in the last Congress "*Universal Military Training*."

It has been humorously stated that statistics may be worse than d—d lies and if statistics are "hand picked" by some individual in an attempt to bolster up a pet theory, there is reason to question the deductions. But here we have an unbiased governmental report, which I wish to demonstrate to you, by these suggestive extracts, as the greatest source of information to the medical profession. May we all utilize this for the welfare of the next generation of our State of Maine.

A LEGEND OF GUISLAND.

Some time since a story was read concerning Dr. Laennec's advice to old King Grallon, and now we have a similar though briefer legend concerning Dr. Guisland, the famous alienist of Belgium. The City of Ghent before the war rejoiced in the presence in one of its squares of a fine bronze statue of Guisland, a man of great fame throughout Belgium for his famous cures in the domain of insanity. During the occupation of Ghent by the Germans they carried off the statue, planning to melt it down into guns or ammunition, but it did not materialize for some reason or another. Whilst the statue was absent and much lamented, the people used to say to one another: "Oh, never mind, Guisland has gone, but he will come back. The Kaiser has gone crazy and they had to call Guisland in consultation." At last the war is over and Dr. Guisland is once more back in Ghent, and in his effigy of bronze gazes out at the well-loved streets of his former dwelling place, the famous city of Ghent.

Would it not be nice if some legends would ultimately attach themselves to the names of famous physicians of Maine.

SOME CONSIDERATIONS IN REGARD TO THE MENTAL CONDITION OF PRISONERS.

By HENRY M. SWIFT, M. D., Portland, Maine.

In presenting a paper on crime before a medical society, I am confronted at the outset with the question as to how this subject is to be of interest to physicians. In other words, what connection has a consideration of prisoners with the cure of disease? This question may be perhaps answered partially by reminding you that present-day tendencies are pointing more and more to the necessity of our regarding the practice of medicine as pertaining not only to the treatment of the individual patient, but also to the promotion of the general health and welfare of the community as a whole. The growth in importance of the department of public health and the organization of the community service are examples of this tendency.

It is not difficult to recognize that crime is a social question just as tuberculosis and insanity are social questions. The relation of crime to insanity and its allied disorders is manifested by the fact that so considerable a number of prisoners show evidence of mental abnormalities of one kind or another. In regard to insanity it must be admitted that this subject, although of tremendous social importance, offers little of interest to many practicing physicians. Nevertheless, courses in mental disease have for many years been prescribed in the curricula of medical schools, showing that it is generally regarded as a branch of medicine. In the same way, inasmuch as so many prisoners are undoubtedly mentally abnormal, it might appear that their study and consideration is not intrinsically alien to medical trends of thought.

It also occurs to one that the problem of the causation of crime resembles in certain respects the problem of the causation of disease. No disease, whether physical or mental, can be scientifically managed unless studied with a view to the removal of its causal factors. In tuberculosis, for example, a case cannot be disposed of by saying merely that the patient has a cough and needs a cough syrup, as in former days. We now take into consideration that tuberculosis is caused by a definite bacillus, that certain environmental conditions are favorable to its development, and that many individuals are especially susceptible. The physician interested in the problem of tuberculosis is concerned

*Read before the Maine Medical Association meeting at Augusta June 29, 1920.

not only in the treatment of the disease itself, but he feels it equally important to know what conditions in the community favorable for its development can be corrected, so that its prevalence may be diminished. Hence legislation applying to the care of milk, killing of diseased cattle, spitting in public places, etc. The importance of the search for causal factors in disease is also exemplified in the management of nervous conditions, as neurasthenia and psychasthenia. In these the causal factors concerned in their development are numerous and variously combined in different patients. Here we have often to deal with individuals naturally neurotic, in whom active nervous manifestations have been brought out or aggravated by circumstances, such as overwork, worry or unfortunate family relations. Thus in many cases of this type it is evident that the first step in treatment is the elimination of unfavorable environmental conditions.

In much the same way one of the problems of the criminologist is the determination of conditions in the social life of the community tending to the development of crime and their elimination whenever practicable. Among environmental conditions which have been thought to promote crime have been mentioned poverty, lack of parental control, and bad associations of various kinds. Unfortunately the problem is not usually as simple. In much the same way as nervousness often arises in persons with a constitutionally weak nervous organization, so also many criminals appear to be the victims of inborn constitutional defect. Peculiarities of mental make-up in offenders often manifest themselves early in a natural instability of temperament, which is shown even in childhood by restlessness and by lack of application to school work, with resulting truancy. Not infrequently an important element seems to be a lack of general intelligence, sometimes of so extreme a degree as to justify the diagnosis of mental deficiency. Thus among 175 prisoners examined at the Thomaston State Prison there were found 30, or 17 per cent., with a mental age of under 10½ years, who were classed as mentally defective, 30 per cent. showed a mental age of 12 years or under, and might be considered as subnormal or border line defectives, while many others, although not sufficiently lacking in mental capacity to be classed as defective, appeared to be of below average intelligence.*

In this connection it may be interesting to mention the proportion of mental deficiency as found in the different types of offence because

* These numbers do not include a number of foreign born prisoners who were apparently of a low order of intelligence, but whose English was too deficient for formal tests.

the social problem involved varies. In crimes of acquisitiveness, as larceny, breaking and entering, and similar offences, 10.8 per cent. were considered mentally deficient; in crimes of violence—murder, manslaughter and assault—11.8 per cent., while in sexual crimes—rape, incest, etc.—the proportion of mentally defective rose to 36 per cent. In other words, the percentage of mental defect among sexual crimes was over three times as great as in crimes of acquisitiveness and crimes of violence. It may be noted, in passing, that the various figures given above are substantially in accord with the findings obtained in surveys of other prisons. Let it not be understood, however, that in cases of this type lack of intellect is to be considered the sole factor in the delinquency. Indeed, many persons of low intelligence never commit crimes and are often perfectly respectable members of society, under favorable conditions even being capable of self-support by simple kinds of work not requiring especial brain power. It is rather those individuals in whom low grade of intellect is combined with character defect from whom the ranks of the actual or potential offender are recruited.

We have regarded certain types of criminals as mentally abnormal. Let us consider, for example, in what manner they differ from ordinary people in their reaction to punishment. We might first ask ourselves the question as to why the majority of individuals keep out of prison. The most obvious answer to this is perhaps that the majority of people are fortunate in being so constituted that they are capable of acquiring reasonably correct ethical principles and really have little inclination to commit serious crimes. Others avoid crimes because they are afraid of being punished; that is, the fear of the law acts as a deterrent. In the case of the criminal, on the other hand, punishment does not always act as a deterrent, as is shown by the fact that he so frequently relapses into crime after his release from prison. Thus in a group of 83 Thomaston prisoners committed for larceny, breaking and entering, and allied offences, 67.5 per cent. had in one way or another been in previous conflict with the law, that is to say, only 26 out of the 83 were, strictly speaking, first offenders.

If some one of us were so unfortunate to receive a term in prison, does it seem probable that he would be found there a second time after his release? Can recidivism of prisoners be explained on grounds other than they are mentally abnormal in some way? For illustration I will cite the following case:

Prisoner, aged 27. At the age of 12 sent to the Reform School for stealing a horse. Later prison sentence for theft. After his re-

lease he enlisted in the army, but was dishonorably discharged for stealing, with 18 months in a military prison. A little later another prison sentence for theft, after which he was paroled, but re-committed on account of further continuance of his criminal propensities. Here is a man intelligent in some respects and perfectly capable of earning a good living and given every opportunity to do so after being paroled. He had every incentive to lead an honest life, with little prospect of profit from a criminal career, inasmuch as he seems to have been rather easily apprehended in all of his operations. Yet the previous punishment received proves to have been absolutely without deterrent effect inasmuch as after being paroled and given steady work he leaves his place of employment, makes another crude attempt to steal and is promptly re-apprehended.

Another prisoner, who had been paroled after serving two years for larceny, fell in with one of his former associates, committed another theft and was returned to prison in less than a week.

These cases, although extreme, are not typical. Criminal careers such as these are hardly to be explained on the theory that the prisoner does wrong by deliberate choice, but rather as being conditioned by some defect in the mental make-up upon which develops the stealing habit, resembling perhaps the alcoholic or the drug habit, and sometimes fully as difficult to overcome.

Formerly, and to some extent at the present time, the chief idea in the waging of the war against crime was punishment pure and simple. It was considered to be the duty of society to inflict retaliation upon the offender and *to make him suffer*. The ideal of modern penology tends more and more to the view that many criminals are unfortunate individuals, and its ideal in their disposition is not punishment but protection to the community, a perfectly sensible and practical aim and one which is not justly open to the charge of sentimentalism. This idea of protection to the community is also associated with measures directed to the reform of the offender in suitable cases. Instead of the eye for eye and tooth for tooth doctrine, the present-day criminologist studies the individual offender with a view to determining as to whether anything can be done to turn him toward an honest career, or, if this is impossible, as to what disposition will be most effective in protecting society against him.

It is in accord with this spirit that prisons have been supplemented by reformatories for the younger criminals and that systems of probation, parole and the indeterminate sentence have been instituted in many States. Under the indeterminate sentence the period of im-

prisonment is not fixed, the idea being that the prisoner shall remain segregated from the community as long as it is necessary to bring about some sort of mental rehabilitation, just as a physician sends a patient to a hospital, not for so many weeks or months, but until such time as he is in a proper condition for discharge. In Maine a prisoner may be granted a trial release at the expiration of a minimum sentence if the parole board considers this advisable. While thus on parole he is under a certain amount of surveyance and may be returned to prison at any time before the expiration of a maximum sentence. This might be regarded as a modification of the indeterminate sentence and is apparently an excellent plan.

I have analyzed a group of 42 of the younger prisoners committed for larceny, breaking and entering, and allied offences. In this group the essential point of similarity does not lie in the grading of intelligence by formal tests, but rather in a constitutional tendency to conduct abnormality as shown by the life histories. These histories indicate frequently early difficulty of control, distaste for school, with lack of application for study, truancy, tendency to drift to bad associates, roaming with frequent change of occupation, and especially diminished capacity to profit by the ordinary forms of admonition and punishment. In the majority a greater or less degree of intellectual defect appeared to be present. The data obtained may be of sociological importance. Of these 42 constitutional offenders about one-half gave a history of bad heredity, most commonly alcoholism in the father. About three-fourths showed marked stigmata of degeneration, such as high or narrow palate, prominent lower jaw, and peculiarities in the bony contour of the head. These stigmata do not indicate necessarily criminalism, but are a frequent accompaniment of various forms of defective mentality.

In respect to previous delinquency, 19 or nearly one-half, gave history of truancy, 13 had been inmates of reform schools, and 24 had had previous jail or prison sentences.

In regard to occupation, the majority of this group might be classed as unskilled, not more than one-fourth being considered experienced in any particular line of work. The histories indicated also a tendency to change jobs frequently and habits of wandering about in different sections of the country.

As to school attainments, only 9 out of the 42 had reached the 8th grade. Of three who had entered the high school, only one went through to graduation.

In regard to intellect as indicated by formal tests, six showed a

mental age of under 10½ years. Of the remainder, 16 tested under 12 years, 14 between 12 and 14 years, and 6 over 14 years.

Estimates in regard to early family environment could be only approximate, because no facts were available except those given by the prisoners themselves. It was judged that in one-third to one-half of the cases the family influence had been reasonably good. On the other hand, it was surprising how frequently were noted in regard to the parents statements to the effect that the prisoner had become an orphan at an early age, that he had left the family and been brought up by relatives, that the parents had been divorced, or that one parent had died and there had been a second marriage. Thus 10 out of the 42 had had a step-parent, who seems sometimes to have been a disturbing element in the family life.

Alcohol appears to have been an important factor in only six of these cases; 10 of the 42 said they were total abstainers. In the others indulgence in alcoholics was apparently moderate and of minor significance.*

From data obtained from analyses of this kind it is learned that many potential offenders have begun to show peculiarities of disposition and behavior at an age before habits and traits of character become fixed, and when remedial measures may be expected to prove most effective.

It is the prevailing opinion that by far the best results are obtained when these atypical and potentially asocial individuals can be taken in hand while still very young. In school children backwardness, lack of application, truancy and insusceptibility to the ordinary methods of discipline and control should suggest investigation. Appropriate measures applied at this time may often prevent the formation of criminal habits.

In any application of remedial measures, whether in children or in adults, I feel it is of foremost importance to appreciate that one is often dealing, not with normal individuals who do wrong from deliberate choice, but with weak, unfortunate persons who are victims of an inborn constitutional defect.

* These figures are in rather marked contrast to those relating to crimes of violence and sexual offences in which alcohol is frequently an important factor.

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Editorial Comment.

MEDICAL DEFENSE AND AFTER.

Having accepted medical defense, members will be wanting to know what they are to do next. The answer is: If you are insured, keep on with your insurance, if you so desire, until defense gets into working order. If insured, talk the matter over with the next agent whom you meet and find out from him, and the next one also, just what they would like to do in joining in with us. Or will they want to keep away from us just as much as we may want to keep away from them? Will they unite with us in hiring the same attorney to defend their cases? This and other questions will arise and be settled in due season. Those who are not insured will go on as usual.

The business of the President and Secretary will begin when a case first turns up, and they will collect information for our attorney on the forms soon to be issued to them for direction. Now let every member do his share and hand in, insured or not, the very first inkling that he gets of a suit threatened against him. Do not hire any attorney, or inform anybody whatsoever of the troubles in sight. See the secretary or the President, or write to them at once. The Secretary will send or hand you the necessary paper to sign, and the President will then join with him in trying to effect a quiet settlement, and in having a heart-to-heart talk with the physician who is mostly to blame for

starting the suit by injudicious remarks. Remember that nothing was ever fashioned into shape at once. Medical defense must have time to get shaped into its proper uses and medical value.

The less you say outside concerning a threatened suit the better; the more you say to the President and Secretary the better still. Do not forget that thousands of physicians in this country carry no insurance at all, but rely implicitly on medical defense. It is only in the East that insurance has come into so much vogue as a "protection". But it does not protect very much, if you are insured for a maximum of \$5,000 and a jury casts your corporation for \$26,000, as in a late trial. Although insurance is valuable at our present juncture, we must remember always that if we work together we are stronger than any insurance, as is proved every year wherever medical defense has been adopted.

You do not have to love every physician, yet you are not to hate any of them. Be as friendly as you can to all. If you have the slightest inkling of what is threatening a fellow practitioner, bear in mind that conditions have changed since the patient consulted the first practitioner. Moreover, we do not know the handicaps under which the doctor worked. And finally, a patient who sees the possibility of some easy money will not truly represent the other side, so that, in justice to all, it is best to say, "I don't know"; "I was not there to see you at the time"; "I have never seen a case like yours"; "I could not say anything about your condition now, unless I had seen you when it occurred." Let such be your talk when approached, and last of all, take and keep a solemn oath that you will never accept a bribe, however big, to induce you to go into court against another physician.

I want every physician to live up to a motto like this: I will defend every physician, whose cause is just and right, so that possibly some time in my life I shall want every physician to defend me in a similar case.

J. A. S.

CASE REPORTS.

One of the causes of lack of progress in medicine in all its branches is the failure of those who see cases of disease in all its manifold diversities to make good case reports, to read them and to preserve them in manuscript or in print. Everybody knows what American canning has done for the food question all over the world, and there is no reason why the art of canning knowledge should not be advanced by American physicians. In making case reports a certain freedom of language is indispensable, for it is impossible to read

with comfort, or to listen agreeably to what one might call bald-headed cases, filled with initials, figures, laboratory jargon, and so on. Although a certain conciseness is desirable, yet chopped-up words and hashed literature are not pleasant to hear or to see. It is an art to be readable.

Here is another point in noting cases. Having made them, do not forget to index them, not by the mere name of the patient, for you may often forget that, but also by the name of the disease, so that later on you can surely trace out what you need for your own benefit or for instruction of others. How often we hear said: "Confound it! I had a splendid case once, of so and so, but I have forgotten the patient's name." So we urge you to make a double index by diseases and names, and later you can make better and more faithful case reports.

Unfortunately, there is nothing done in our schools to teach children how to write even an ordinary letter, so that when they grow up and attend our colleges or medical schools they have no idea of how to express their thoughts. In every hospital, also, at least one interne should be shown how to put reports of interesting operations and diseases into readable shape.

We have great men in medical Maine, but it is really surprising how few of them can put on paper their words, although fluent enough when standing on their feet. How is it that, knowing their ability of speech, they remain for life indifferent to putting those very same worded thoughts on paper?

We look for some improvement in this respect at once, for lack of case reports is a complaint against the JOURNAL. Yet last year we had only as many as two offered us from all over Maine. If you are timid about your style, let "George" put your ideas into fluent language and act as encouraging editor.

J. A. S.

LAY PRESS CRITICISES COURT'S OPINION.

The following clipping comes from the *Lewiston Journal*, and we will leave it to our readers to judge the type of journalism it represents.

"The court calls it manslaughter because a child happens to die without medical treatment but under Christian Science treatment. What does it call cases where patients die under medical treatment? Why not manslaughter, too?"

This is rather a harsh criticism of our courts of justice and the eminent jurists who interpret our laws.

Now, the medical profession has no issue with the Christian

Science, but we feel compelled to point again to the fact that death is and always will be the termination of all forms of life. Just as the laws of our land must be administered by men thoroughly trained in law, and graduates of law schools, so must the health of the communities be left with graduates of our medical schools, whose training represents the most advanced knowledge as to causation and treatment of disease. A medical graduate of to-day must have intimate knowledge of the development and cellular structure of the most wonderfully complicated machine in the world, viz., the human body; the structure and function of all the organs; the changes due to disease, and, finally, how to deal with disease. It requires from five to seven years of college study for a degree and one to two years of hospital training to acquire sufficient knowledge to begin.

It is, unfortunately, true that no mortal is perfect, free from mistakes or errors in judgment, but when members of the medical profession have utilized all available knowledge in the case of a patient and death ensues, it is reasonable to assume that death was inevitable. On the other hand, if death was due to negligence, the courts will not hesitate to punish the guilty medical practitioner. The courts rightfully hold that the best is none too good for the public, and that the minor when sick should have the benefit of the highest possible skill and experience.

THE ANNUAL MEETING.

The annual meeting at Augusta was a very successful one in many ways. There was more than the usual attendance. The program was very good, and the business of the Association transacted important.

In the House of Delegates the Medical Defense Committee reported a plan that was accepted by the Association and is now in operation. We hope it will work out as well as it has in other States, and that every member will take advantage of the help offered by this Association. Blanks are now being considered, also a permanent attorney for the work. It was voted next year to have a President-elect, who shall be in the House of Delegates and become familiar with the work before he takes over the charge of the Association as acting President. In the past this position has been considered simply an honorary one, but in the future it is hoped the man chosen will come into the office fully equipped to carry on the work of the Association with a better understanding of its needs, and willing to put in a year of good hard work in helping push things along.

It is planned to hold two meetings of County Secretaries this year, one in September, the other before the annual meeting. Hotel expenses and entertainment will be furnished by the Association. It is sincerely hoped that a man will be found in each county willing to hold the position of Secretary for a number of years, and that he be made one of the delegates to the annual meeting each year.

It is expected that each councilor will visit all the societies in his district and help in every way he can to get in every physician in the county as an active member, help with his advice whenever needed, and be sure to be on hand at Bangor next June with his report.

There will be important work for the committees this year. Each chairman should get in touch with his committee and get down to business as soon as possible. At the request of the American Medical Association a new committee was appointed, with Dr. Bristol as chairman, to co-operate with the State Teachers' Association in health matters pertaining to schools. There is a great chance for this committee to get in some good work. The Legislative Committee and Hospital Committee should have their hands full with the work planned for the year.

With the help of Medical Defense every physician in the State should become an active member and help make the influence of the medical fraternity mean something. Our slogan this year should be *at least a thousand members.*

B. L. B.

THE BEGINNING OF MEDICAL PRACTICE IN NEW ENGLAND.

"It pleased ye Lord to visite them this year (1633) with an infectious fevoure, of which many fell sicke, and upward of 20 persons dyed, * * * * and in ye end (after he had much helped others) Samuel Fuller, who was their surgeon and phisitian, and had been a great help and comfort to them."

This is the tribute paid by Bradford in his history of the first man to practice medicine in New England and probably on the entire Atlantic coast. What better epitaph could anyone desire than to have it recorded in history that he had been "a great help and comfort" to his associates.

From the humble beginnings of this doctor, who came to Plymouth in the Mayflower three hundred years ago, has developed the great field of medical practice of to-day.

A deacon in Elder John Robinson's church, Samuel Fuller min-

istered alike to the spiritual and the bodily needs of the Pilgrims. And not alone was his help limited to the Pilgrims, for we find repeated instances where he went to minister to the needs of the Indians and to the people of the Massachusetts Bay Colony.

In 1628 and again in 1629 he was summoned by Governor Endicott to treat the sick in Charlestown and in Nomkeag (now Salem.) Letters from Governor Endicott to Gov. Bradford accord him high praise for his professional service and also show that to his medical knowledge must have been added superior ability as a diplomat, for he evidently succeeded in breaking down the barriers of religious differences and disagreements between the two colonies and in laying the foundation for their union near the close of the century.

In 1630 it is recorded in one of his letters to Gov. Bradford: "I have been to Mattapan (now Dorchester) and let some twenty of these people blood." What may have been the nature of the epidemic that he there had to combat, it is at least certain that his treatment was vigorous and in accord with the best medical science of his day.

We find no record showing where he obtained his knowledge of medicine, and after all

" 'Tis not the creed that makes the man,
But 'tis the man that justifies the creed."

Through the pathless forests from Cape Cod to Cape Ann and across the uncharted waters of Massachusetts Bay he left the record of a life devoted to the service of his fellow men. The untrodden wilderness his field, the wigwam of the Indian, the humble home of the Pilgrim and the Puritan his hospital, sachems and governors, as well as the humblest in the land, his patients, he ministered alike to all and gave to all that lavish and unstinted philanthropy of service that ever characterizes the true physician. He died in the summer of 1833, lamented by all the colonists.

CHARLES H. BANGS.

COMMUNICABLE DISEASES.

The JOURNAL has received from the State Department of Health its bulletin on such diseases, and after reading it carefully we wish to say that it is a piece of medical public health work of inestimable value to physicians, teachers, and an interested public. In a few pages are compressed the most valuable suggestions possible for the prevention, notification and care of a large number of diseases of great danger to the community.

We note with extreme interest the point raised concerning the

use of raw milk, or cream, for ice cream as sold so enormously in Maine. Concerning the heating of milk or cream for this purpose we actually never had heard in spite of pretty wide reading. Is there any means of knowing if all of the creams supplied to the public has ever been treated in this way previous to freezing? So, too, in connection with ice cream—a daily food, as it were, of thousands of people—we wonder what investigation is made concerning typhoid carriers attached in any place to the milk supply.

This pamphlet is of value to every health officer in Maine, and should always be kept ready at hand for instant reference. It is indeed a handy pamphlet to have on hand.

The "Reminders," under various important diseases, are timely and useful.

Every bulletin issued by our Department of Health shows value to physicians and ability on the part of all concerned in putting it together into readable shape.

J. A. S.

HEALTH NEWS BULLETIN FOR JULY.

The Health News Bulletin for July is at hand and contains two very important items, "A Speaker's Bureau" and "Increased Cancer Deaths in Maine."

From the first we learn that a bureau of speakers on public health has been arranged, with a list of speakers, for Chambers of Commerce, Rotary Clubs, and others. This work of co-operation of the State Department of Health and the Public Health Association ought to accomplish much. We note an impressive list of lecturers, and we hope that when the list of topics is issued it will contain the important subject, "Conservation of Vision." For several years a leading specialist in Maine spoke on this impressive subject on his own initiative, and we hope that with the backing of the departments just mentioned, wider audiences may be obtained.

In 1900 there were 500 deaths from cancer in Maine; in 1919 there were 888. This should not, however, cause alarm, since it is probable that twenty years ago many cases were never reported, so that the increase is only probable, not precise. Let us bear in mind that cancer is not inherited, it is not contagious, and that it is curable if taken early in hand.

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Abbott, H. W., Waterville	Cragin, D. B., Hartford, Conn.
Boyer, E. W., Waterville	Coombs, G. A., Augusta
Bunker, L. G., Waterville	Clason, S. O., Gardiner
Beach, S. J., Augusta	Cole, Fred M., Gardiner
Beane, C. H., Hallowell	Carter, F. R., Augusta
Badger, F. H., Winthrop	Davies, O. C. S., Augusta
Berube, D. T., Augusta	Desiardin, Arthur, Waterville
Bristol, L. D., Augusta	Frederick, H. J., Augusta

Fish, E. P., Waterville
 Farrell, C. G., Gardiner
 Goodrich, M. S., Waterville
 Gousse, W. L., Fairfield
 Harris, W. H., Augusta
 Hill, J. F., Waterville
 Hill, F. T., Waterville-Boston
 Hardy, T. E., Waterville
 Hall, H. W., Hallowell
 Hendee, Warren, No. Vassalboro
 Hambleton, M. P., Augusta
 Hurd, B. P., Waterville
 Kagan, S. H., Augusta
 Kraus, Dorris P., Augusta
 Libby, A. B., Gardiner
 Mabry, Chas., No. Vassalboro
 Merrill, P. S., Waterville
 Milliken, H. A., Hallowell
 McKay, R. L., Augusta
 Nutting, J. D., Jr., Hallowell
 Newcomb, C. H., Clinton
 O'Connor, W. J., Augusta
 Poulin, J. E., Waterville
 Priest, M. A., Augusta
 Parizo, H. L., Waterville
 Reynolds, R. L., Waterville

Rowe, F. E., Augusta
 Strout, Arthur, Gardiner
 Strout, F. E., Gardiner
 Sawyer, Alton, Gardiner
 Stubbs, R. H., Augusta
 Simons, R. D., Gardiner
 Sturtevant, A. H., Augusta
 Shaw, A. A., Clinton
 Shaw, John F., Fairfield
 Simmons, C. R., Oakland
 Sanborn, Warren, Winthrop
 Towne, J. G., Waterville
 Thayer, F. C., Waterville
 Turner, O. W., Augusta
 Tyson, F. C., Augusta
 Thompson, H. E., Augusta
 Washburn, G. E., Augusta
 Walker, F. D., No. Vassalboro
 Williams, H. E., Mt. Vernon
 Young, A. G., Augusta
 Bartlett, F. H., Fairfield
 Milliken, J. S., Readfield
 L. L. Mann, Augusta
 John C. Lindsey, Waterville
 G. W. Alexander, Gardiner
 V. C. Totman, Oakland

KNOX.

Adams, F. B., Rockland
 Bartlett, F. O., Rockland
 Brown, F. F., Vinalhaven
 Coombs, G. H., Waldoboro
 Campbell, Fred, Warren
 Ellingwood, Wm. E., Rockland
 Green, A. F., Camden
~~Rees~~ Rees, A. W., Rockland
 Frohock, H. W., Rockland
 Hadley, L. W., Union
 Hart, W. F., Camden
 Hall, Walter, St. George

Hutchins, J. G., Camden
 Keller, B. H., Appleton
 Lyford, W. F., Vinalhaven
 Lyonburg, Franz, North Haven
 North, C. D., Rockland
 Sanborn, J. W., Waldoboro
 Spear, W. M., Rockland
 Silsby, E. B., Rockland
 Stetson, E. T., Damariscotta
 Steward, Carlton, Rockport
 Weidman, S., Rockport

OXFORD.

Binford, H. J., Mexico
 Bisbee, C. M., Rumford
 Bartlett, H. L., Norway
 Bicknell, R. W., Canton
 Bradbury, B. F., Norway
 Farris, H. R., Oxford
 Fitch, H. F., Brownfield
 Gehring, J. G., Bethel
 Greene, J. A., Rumford
 Haskell, W. B., Oxford
 Hammond, C. F., Augusta
 Hanlon, O. L., Ridlonville
 Littlefield, J. G., So. Paris
 Morse, F. W., Canton
 Marcon, L. B., Berlin, N. H.
 Moody, H. A., Rumford
 McCarty, E. M., Rumford

Nile, J. A., Rumford
 Noyes, L. F., Rumford
 Noyes, E. S., Rumford
 Noyes, H. L., Rumford
 Pease, W. M., Dixfield
 Pettingill, O. S., Hebron
 Rowe, W. T., Rumford
 Stewart, D. M., So. Paris
 Stanwood, H. W., Rumford
 Sturtevant, J. M., Dixfield
 Sturtevant, J. S., Dixfield
 Thibadeau, J. A., Rumford
 Wight, E. A., Bolster's Mills
 Wight, I. H., Bethel
 Wheeler, F. E., West Paris
 Wheet, F. E., Westbrook

PENOBSCOT.

Bayard, C. H., Orono
 Bryant, B. L., Bangor
 Brown, E. E., Bangor
 Bunker, D. W., Bangor
 L Blanchard, C. H., Pittsfield
 Burgess, C. H., Bangor
 Chapman, H. M., Bangor
 Coe, T. U., Bangor
 Edmunds, C. E., Bangor
 Emerson, W. M., Bangor
 Fellows, W. E., Bangor
 Fellows, A. W., Bangor
 Foss, Q. H., Bangor
 Harrison, Robinson, Bangor
 Hasty, W. Q., East Hampden
 Higgins, G. I., Plymouth
 Hirst, Barbara, Bangor
 Howes, L. M., Bangor
 Hunt, H. J., Bangor
 Hunt, W. L., Bangor
 Hedin, C. J., Bangor
 Jackson, H. L., East Eddington
 Jangigian, Robert, Bangor
 Johnston, H. W., Hampden
 King, H. A., Bangor
 Lethiecq, G. A., Brewer
 Mansfield, B. M., Bangor
 Marquis, Edw., Old Town
 Murphy, J. H., Dexter
 Mason, L. S., Bangor
 Mason, W. C., Bangor
 McCann, Daniel, Bangor
 Milliken, H. S., Bangor
 Marsh, S. N., West Enfield
 McNeil, H. D., Bangor
 McCurdy, C. L., Bangor
 Madden, M. C., Old Town
 Mansfield, Edw. R., Millinocket
 Mitchell, R. L., Carmel
 Nealley, E. T., Bangor
 Nickerson, N. H., Bangor
 O'Brien, C. R., Bangor
 Osgood, H. W., Bangor
 Philbrick, C. S., Bangor
 Preble, James, Old Town
 Porter, Edw., Pittsfield
 Peters, Wm. C., Bangor
 Purrington, W. S., Bangor
 Redman, S. J., Exeter
 Robinson, D. A., Bangor
 Russell, J. P., So. Brewer
 Scribner, Herbert, Bangor
 Skofield, E. B., Charleston
 Sanger, E. B., Bangor
 Small, A. E., Bangor
 Snow, H. E., Bangor
 Simmons, W. H., Bangor
 Smith, A. K. P., Bangor
 Scammon, C. S., moved to Portland
 Strout, A. C., Garland
 Snow, H. E., Bucksport
 Starrett, J. F., Bangor
 Taylor, C. J., Bangor
 Tomlinson, Edw., Orono
 Thompson, J. B., Bangor
 Twitchell, A. H., Old Town
 Thomas, C. P., Brewer
 Thomas, C. M., Brewer
 Woods, J. B., Bangor
 Way, Geo. F., Jr., Lincoln
 Walton, R. D., Frankfort
 Weymouth, F. D., Charleston
 Wright, Q. J., Bangor
 Woodcock, Allan, Bangor
 Woodcock, G. M., Bangor
 Worth, H. D., Bangor
 Whitney, W. E., Bangor

PISCATAQUIS.

Bumps, W. A., Dexter
 Bundy, H. C., Milo
 Crosby, W. H., Milo
 Doore, G. E., Guilford
 Flint, E. T., Foxcroft
 Freeman, F. H., Sangerville
 Hall, C. C., Foxcroft
 Hathaway, W. L., Milo
 Marsh, R. H., Guilford
 McDonough, T. H., Brownville
 McFadyen, James, Milo
 Pritham, F. J., Greenville
 Schriver, A. E., Brewer
 Snow, H. A., Milo
 Stanhope, A. H., Dover
 Stanhope, C. N., Dover
 Wilson, J. H., Cambridge
 Merrill, E. D., Foxcroft
 Purington, W. A., Foxcroft

SAGADAHOC.

Barker, B. F., Bath
 Black, R. A., moved to Sullivan
 Fuller, E. M., Bath
 Fox, Horace, Bath
 Gregory, G. A., Boothbay Harbor
 Hannigen, Robert C., Bath
 Irish, I. C., Bowdoinham
 Kershner, W. E., Bath
 Lincoln, J. O., Bath
 Marston, Eben J., Bath
 Mullin, S. S., Bath
 Peaslee, C. A., Bath
 Price, W. N., Richmond
 Peabody, F. B., Richmond
 Stort, A. A., Woolwich
 Still

SOMERSET

Ames, J. D., Parsons, Kansas
Caza, O. J., Skowhegan
Dascombe, L. A., Skowhegan
Hopkins, P. O., Bingham
Milliken, W. S., Madison
Marston, H. E., No. Anson
Moulton, J. D., Hartland
Piper, J. O., Solon

Richardson, C. E., Skowhegan
Robinson, F. J., Fairfield
Smith, H. W., Norridgewock
Sawyer, W. G., Madison
Stinchfield, W. S., Skowhegan
Tozier, F. L., Fairfield
Young, G. E., Skowhegan

WALDO.

Fairchild, S. L., Searsport
Hoit, Chas. E., Liberty
Kilgore, H. L., Belfast
Pattee, S. C., Belfast
Small, F. C., Belfast

Small, E., Belfast
Stevens, C. H., Belfast
Stevens, E. L., Belfast
Vickery, O. S., Belfast

WASHINGTON.

Armstrong, C. M., Robbinston
Bennett, E. H., Lubec
Bennett, D. F., Lubec
Barker, N. B. T., Woodland
Blair, F. I., St. Stephen, N. B.
Best, H. H., West Pembroke
Bunker, W. H., Calais
Crane, J. W., Dennysville
Curtis, A. K., Danforth
Cook, C. E., Calais
Cleveland, W. F., Eastport
Dyas, I. E., Eastport
Dyas, A. D., St. Stephen, N. B.
Deinstadt, W. M., St. Stephen, N. B.
Gilbert, W. J., Calais
Gray, W. E., Milltown, N. B.
Holland, R. A., Calais
Harmon, A. R., Lubec

Hunton, S. L., Machias
Johnson, C. E., Princeton
Johnston, S., Vanceboro
Longfellow, J. W., Machias
Larsen, O. F., Machias
Miner, W. N., Calais
Murray, Alex., Lord's Cove,
Deer Island, N. B.
Mason, H. B., Calais
Murphy, J. L., Eastport
Marion, J. W. J., Calais
Porter, M. L., Danforth
Sullivan, E. V., St. Stephen, N. B.
Snell, F. W., Eastport
Tustin, Ruth, Eastport
White, E. A., Columbia Falls
Smith, A. L., Machias

YORK.

Allen, Seabury W., York Harbor
Baker, Wm. H., West Buxton
Brown, Lendall H., No. Berwick
Bragdon, Fred A., Springvale
Carty, John D., Kittery Point
Cobb, Stephen A., Sanford
Cochrane, Jasper D., Saco
Cook, Edward C., York Village
Dennett, Carl G., Saco
Devereux, Frank G., Portland
Dolloff, David E., Biddeford
Durgin, Henry I., So. Eliot
Emery, Caleb J., Biddeford
Ferguson, M. H., Biddeford
Goss, Richard A., Sanford
Gordon, Jos. W., Ogunquit
Grant, Hugh D., Bath
Haley, Jesse D., Saco
Hill, Paul S., Saco

Hurd, H. Willis, Biddeford
Hillsley, Harris P., Limington
Jacques, Edwin D., So. Berwick
Jones, Arthur L., Old Orchard
Kelly, Wm. H., Sanford
Kendall, Clarence F., Biddeford
Lamoureux, Arthur C., Sanford
Laroche, Jos. R., Biddeford
L'Heureux, Jean N., Sanford
Lightle, Wm. E., No. Berwick
Lord, Frederick C., Saco
Love, George R., Saco
Maybury, Robert L., Saco
McCorison, James O., No. Berwick
Maynard, Albert C., Fall River, Mass.
Owen, Herbert A., Bar Mills
O'Neill, Eugene D., Biddeford
Precourt, George C., Biddeford
Prescott, Harry L., Kennebunkport

Randall, Jesse A., Old Orchard
 Ross, Frank M., Kennebunk
 Ross, Frank A., So. Berwick
 Ross, H. Danforth, Sanford
 Schafer, John W., So. Berwick
 Small, Fitz E., Biddeford
 Stimpson, Arthur J., Kennebunk
 Shapleigh, Edward E., Kittery
 Smith, Wm. W., Ogunquit

Smith, Frank W., York Village
 Stewart, John C., York Village
 Sawyer, Samuel G., Cornish
 Stickney, Laura B., Saco
 Thompson, C. E., Saco
 Traynor, Chas. F., Biddeford
 Varrell, Wm. W., York Harbor
 Weeks, George W., Cornish
 Wentworth, Benj. F., Scarboro

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 G. A. Allen, Lovell
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 J. U. Coe, Bangor
 R. T. Goodhue, Portland

R. F.

Leon T. Hale, So. Portland
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 Lelia Higgins, Wilton
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 E. M. Northcott, Portland
 T. H. Steven, Boothbay Harbor

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Necrology.

JUSTIN ADFER WALLING.

Milbridge, 1858-1920.

Two years before his untimely death, Dr. Walling suffered quite a while from dilatation of the heart, brought on by overworking physically at his practice. After a good rest he remained in excellent condi-



JUSTIN ADFER WALLING.

tion until the deep snows of the past winter compelled him again to overexert himself in wading through deep and heavy snowdrifts on his walks to his patients. During an attack like those of previous years he suffered terribly, and was obliged to rest many times before he could reach his home again. He suffered from distressed breathing, and he raised considerable pinkish froth. The symptoms all pointed to aortic

obstruction with dilatation. After a few days he improved considerably and seemed on the road to perfect health once more, when on the 2nd of March, 1920, after eating a hearty dinner, and being in apparently the best of spirits, chatting freely and merrily with his wife, as was his habit in former years, he died in an instant without a single premonition of danger.

Dr. Walling was the son of Dr. George Henry and Phoebe Whiting Walling, and was born in Burrillsville, Rhode Island, October 29, 1858, and soon after came with his parents to Harrington, where his father practiced for several years. Young Walling was educated at the Waterville Classical Institute and was graduated at Colby in the class of 1879. He studied medicine at Bowdoin and obtained his degree in 1882, submitting for knowledge gained a thesis on "Typhoid Fever", a topic in which he remained permanently interested. He settled in Jonesport, practiced there four years, and then removed to Milbridge for life in 1887. He married, April 2, 1883, Miss Sophia Wilson, who survives him.

As his half-tone shows, Dr. Walling was a bright and entertaining personage, much given to conversation, and to small pranks and jokes played upon children and neighbors, which never hurt the feelings of a soul involved. He was not given to the writing of medical papers, but he attended the county meetings often, invariably had something to say concerning the papers read, and for his skill in this direction of medical progress he was rewarded with the Presidency of the Washington County Medical Society in the last year of his life. His judgment of diseases was sound and his diagnosis unerring, and as a man and physician he invariably gave the best that was in him for his trusting patients.

J. A. S.

FELIX BARRETT.

Westbrook, 1860-1920.

Dr. Barrett, one of our pleasant, much-liked members, died at his home in May, after a long and terrifying illness caused by an incurable and inoperable cancer, lasting from the beginning of the previous autumn of 1919. He faced the inevitable for months with unflinching courage and continued to lay out work ahead for others to do until the last of his life.

He was the son of Joseph and Olive Cabana Barrett, and was born

in the hamlet of St. Louis, P. Q., Canada, August 9, 1860, and when quite young he came to Westbrook as a laborer in the mills. With strong determination to advance his fortunes he picked up some education at every hand, and at about the age of twenty he began the study of medicine with a well-known practitioner of Westbrook, Dr. M. H. Martin. He followed out also year after year the needed courses of lectures, obtaining his degree at the U. S. Medical College in New York in 1886. Not wholly satisfied with this bit of parchment, he took another course of lectures at the Bowdoin Medical School and obtained



FELIX BARRETT.

a second degree in 1893. Meanwhile he had been practicing steadily at Kennebunkport, an active field in the summer, but rather solitary later on, until the ensuing spring. He worked along steadily, ever with an eye open to a larger field for his energies, which he found at last in Westbrook in 1890. Removing there on the first chance, he renewed his former acquaintances with friends, and soon met with a high degree of success. In 1896, foreseeing the absolute need of a hospital in the city he set up one of fourteen beds for himself, and open to other

practitioners on the staff. For the rest of his life he devoted himself to electro-therapeutics, in which he had unbounded faith and reliance, wrote papers concerning its value, and was at one time President of the New England Electro Therapeutic Society. He also made up his mind for surgery, followed special courses, and for a man who had taken up that operative branch, as one might say, rather late in life, he had good success and did most of the major operations with good results. He also studied the manipulation and interpretation of the X-rays, and succeeded also with the use of those for diagnosis and treatment.

I note that at a clinic held at the Maine General Hospital in 1903, on the semi-centennial of this Association, he exhibited an odd case of separation of the upper epiphyses of the femur on both sides in a child of three with a hair lip. It was at first supposed to be a case of congenital dislocation at the hip joint, but, much to the exhibitor's pleasure, it proved to be the much rarer condition mentioned above.

Dr. Barrett married in 1886 Miss Cora Isabelle Cloudman, of South Windham, and is survived by her and two daughters.

The physician who establishes in any center of population a standard, well-equipped, modern hospital as Dr. Barrett established his, proves himself a good citizen, an advancer of public health, deserves the support of the people roundabout, and in leaving his hospital behind upon his death, makes of it an enduring monument to his fame. We are glad to know that others have taken charge of his foundation and carrying it on for the public good of the City of Westbrook.

J. A. S.

JOHN JASPER SEWALL.

Newport, 1851-1920.

Dr. Sewall, one of our past members, but a quiet man absorbed life long in his professional work, began to suffer from cancer of the stomach in October of 1919 and died, after much suffering, at Newport, Maine, February 3, 1920. He regretfully abandoned medical work, of which he had always been fond.

He was the son of George and Elizabeth Sewall and was born at Newburg, Maine, October 9, 1851. His father dying when he was but ten years of age, he was compelled to become a self-reliant youth from that time onward. He learned of his own initiative the common branches of every-day education, and at a very early age began to be a

teacher in the schools. In spite of his youth he knew just how to manage boys and girls even older than himself. He was for several years a most successful teacher, attended at intervals the Maine Central Institute at Pittsfield, and ultimately took to medicine, beginning with a single course at Bowdoin and ultimately obtaining his degree in 1886 at the New York University of Medicine. Soon afterward he married Miss Julia Harding, of Dixmont, and settled for practice in Monroe, where he remained eight years. His wife died about ten years later. During his life in Monroe he went deeply into politics and served two terms in the Legislature. He left Monroe in 1893 for the larger field of Roxbury, Massachusetts, and did good work there for ten years. Feeling once again the "Call for Maine," he settled in Newport for the remainder of his life.

He had a sound reputation as a man of common sense, was reserved in his opinions, hardly ever attended the County Society or State meetings, and seemed to have no inclination to write out his thoughts or the results obtained from his practice in medicine. He traveled in Mexico in 1910, but otherwise remained steadily at home. He loved children, but had none of his own, and was fond of fishing every spring time. He was at one time an examiner of recruits, and is survived by a second wife.

We are sorry that we are unable to present to the JOURNAL any picture of the man as he appeared in the daily walks of his professional life.

J. A. S.

ELIZABETH KINGMAN HERR.

1835—1920.

We regret to announce the death, at an advanced age, of Dr. Elizabeth Herr, widow of a physician once famous in medical Maine. Dr. O. A. Herr, of Lewiston. Those of us who are sixty years of age, or over, will recall vividly the steady appearance at our meetings, for years, of Dr. O. A. Herr, both on account of his striking personality and for his keenness of debate on almost every paper presented. He was indeed ubiquitous with us for years, and his wife, Dr. Elizabeth Herr, was equally a fluent speaker on many occasions. Together, too, they practiced medicine from the same home, one as it were, supplementing the work of the other. Dr. Elizabeth Herr was a nurse in the Civil War, one of the earliest women physicians in Maine, and she owed much of her great success by keeping out of politics as much

as she could, and also out of too prominent progress on the part of women.

It is rare in the annals of medicine to be able to bear testimony to the unity of medical work accomplished by this active, capable, and happily wedded pair of medical practitioners, and for that reason we stop a moment to think it over, and to write these few words of farewell to a worker, lately laid to rest, and of a memorial to her husband, both of them once famous personages in the ranks of our Association.

In the absence of additional information concerning the death of Dr. Elizabeth Kingman Horr, we state, as a matter of historic fact, that she died suddenly at Waterford at the age of 85, in May, 1920, having retired there after a long and honorable practice in Lewiston, soon after the death of her much admired husband.

J. A. S.

Notices.

WHAT IS THE THERAPEUTIC VALUE OF THE HYPOPHOSPHITES?

A research conducted by the Council on Pharmacy and Chemistry shows: There is no reliable evidence that they exert a physiologic effect. It has not been demonstrated that they influence any pathologic process. They are not foods. If they are of any use, that use has not been discovered. The hypophosphites were introduced into medicine by Churchill, who advanced the theory, long since discarded, that the so-called tuberculosis diathesis was due to a phosphorus deficiency. It is now known that little phosphorus, if any, is assimilated from hypophosphites—far less than from phosphorus compounds of ordinary foods. As a result of the power of advertising, many physicians still prescribe hypophosphite combinations.—*Journal A. M. A.* June 12, 1920, p. 1661.

MEDICAL VETERANS OF THE WORLD WAR FORM A STATE ORGANIZATION.

At a recent meeting of the medical officers from the State of Maine who served with our forces during the war, held at the State House in Augusta, it was voted to establish a State organization, the object of the association being at this time very largely to perpetuate friendships made during the war, interest in the Medical Reserve, better co-operation between the Reserve and Regular Corps, and to promote the welfare of members so far as it relates to government matters of interest to them.

The ex-service medical men of the State were well represented at the initial meeting, about one hundred being present, and the following officers were elected:

President—Estes Nichols, Portland.

First Vice President—Bial F. Bradbury, Norway.

Second Vice President—J. G. Towne, Waterville.

Secretary-Treasurer—Frank Y. Gilbert, Portland.

Executive Council—W. L. Cousins, Portland, Chairman; W. C. Peters, Bangor; H. R. Farris, Oxford; J. W. Loughlin, Newcastle; Edgar Flint, Foxcroft.

There are approximately three hundred physicians in the State who are eligible, and if the succeeding meetings are as enthusiastic as the first, there is a big future for this society.

Provision has been made for two live meetings each year to be held during the meeting of the Maine Medical Association. Furthermore, the constitution provides for the sub-division into district societies, similar to Cumberland, where monthly meetings proved unusually interesting and valuable to its members.

WARNING AGAINST UNTRIED MEDICAMENTS.

The United States Public Health Service has issued a circular regarding the use of arsenic preparations in the treatment of syphilis, in which it invites attention to the extensive exploitation of various arsenic preparations which are not related to the arsphenamin group. It is held that the subcutaneous, intramuscular or intravenous use of arsenic in the treatment of syphilis should be confined to the arsphenamin group, as these agents are now of established value and are produced under the supervision of the Public Health Service.—*Journal A. M. A.*, June 12, 1920, p. 1654.

THE NEXT MEETING OF THE A. M. A. IN BOSTON IN 1921.

We are very glad that Boston has been chosen as the seat of the meeting of the American Medical Association for 1921, and we set forth this information very early, in the hope that medical men, and women, too, in Maine, will awaken to the great opportunity offered by this approaching meeting to think over their medical and surgical and public health experiences during the year just past, and the year to come, so as to enroll their names on the program for the meetings. Maine, we regret to say, has not done its share of late in the production of medical papers, and here is a chance to show the rest of the nation in 1921 that there is always something doing, and something doing for advance, in Maine, that State that directs the nation toward the rising sun. Let the County Secretaries advise with members and let papers be written for the County Societies, for discussion and improvement, and let the best of those presented during the winter of 1920-1921 be looked over by the President and the Censors, with a view to advising that they be asked for a place on the program for the A. M. A. in 1921.

POOR TUBERCULOUS PATIENTS SHOULD STAY AT HOME.

The Anti-Tuberculosis Society of Denver, Colorado, has issued a leaflet and sent it broadcast throughout the nation, urging tuberculous patients without abundance of means to stay just where they are. They urge that climate alone does not cure this disease and that those without means going to Colorado in hope of a cure from the climate, and looking for support by obtaining work, will be disappointed. The demand for labor in this direction is oversupplied, as it is. Denver, moreover, has no State or private sanatorium, and most cases must be treated privately with private means. Patients coming to Denver—and Denver is only a single instance of many other Colorado places—ought to be provided with sufficient funds for at least two years of good care. Without this they are better off at home.

In connection with this very laudable leaflet, which we hope will receive due attention at the hands of physicians first, and boards of health afterward, we call attention to the fact that Colorado is becoming somewhat alarmed at the assertion that tuberculosis is on the increase amongst its own native board people. Studies in this direction will prove the truth or falsity of this public dread. At all events, we commend the purpose of the leaflet, and trust that people will be taught

that good care, diet feeding, sanitary rooms and homes will do more for tuberculous patients than mere change of climate with less care than they can get at home.

RAYNAUD'S DISEASE.

We have lately received a copy of the *New Jersey State Medical Journal* for June, and on its front and various successive pages we have discovered and read with great pleasure and gratification a very remarkable paper on this rare disease by Dr. H. P. De Forest, of New York. Not only does the paper contain a list of seventeen cases treated by the writer, but it has illustrations of the various portions of the body attacked by this strange affection, remarks on its pathology, suggestions for successful treatment, and so on, but there is in its columns an unique portrait of Raynaud, together with a very satisfactory biographical notice of the discoverer of the affection which takes his name. Precisely speaking, however, it might be useful for certainty of nomenclature to call it local syncope, or local asphyxia, or finally, symmetrical gangrene.

It is not often that we note so valuable a paper in contemporary medical literature, and in our inability to condense it so that it can be made of practical value to our readers, or to reproduce any of the very curious and invaluable illustrations, case histories, and suggestive treatment, we make it a particular point in this way to call the attention of those interested in the topic of Raynaud's disease. Additionally, it will give us the greatest pleasure imaginable to show the paper, with its pictures, to inquiring colleagues in internal medicine throughout the State.

BOWDOIN MEDICAL ALUMNI ASSOCIATION.

On the first day of the annual session of the Maine Medical Association, June 29, 1920, about fifty graduates of the Bowdoin Medical School lunched together at the Augusta House, and, after remarks by Drs. D. A. Robinson, of Bangor, and L. G. Bunker, of Waterville, adjourned until the following day. At the adjourned meeting, officers of the Bowdoin Medical Alumni Association were chosen as follows:

President—Dr. Luther G. Bunker, Waterville.

Vice-Presidents—Dr. Wallace E. Webber, Lewiston; Dr. Arthur H. Parcher, Ellsworth.

Secretary—Dr. Frank Y. Gilbert, Portland.

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THE CASE OF KING GRALLON, A LEGEND OF LAENNEC.

Quimper, in the province of Finistere in France, enjoys possession of a famous cathedral dedicated to St. Corentin, and in the public square adjacent is a statue of Laennec, the world renowned discoverer of the stethoscope, who was born in that town, and whose stethoscopic centennial was celebrated in 1919. Concerning this cathedral, with its equestrian statue of the mediæval King Grallon, high up on the facade between the towers, and the bronze statue of Laennec, not far out of sight below, the following legend is told:

Once upon a time a workingman of Quimper was going home very late at night, having been kept unusually busy in his shop. As he passed through the square in which the cathedral stands he heard suddenly and most unexpectedly from high up in the cathedral towers a single cough and then another, both cavernous in sound, so he

stopped to listen for more, but none were heard than the separate two, and he went his way wondering.

Passing along the same square on the following night, and late again, he heard once more a series of coughs, persistent, cavernous, granitic, as one might define them. He thought to himself, "It must be that our good old King Grallon way up there on the towers has got a bad cold. It may be pleasant enough up there in summer, for he can see all Quimper at his feet—the distant hills, the curving river, the marriage and christening processions, the open markets, the crowds of people and of animals—and so, too, he can listen to the gossip of the town, but in winter, when the winds blow and snows fall abundantly, it must be pretty hard on the old king's health, way up there, and so much exposed. It must be bad for his health and very dangerous, as all the doctors say, with the influenza everywhere prevailing. The poor old chap can't be very smart, or he would look out for himself and come down and consult our famous Laennec across the way."

Passing again on a third evening along the same route, the workman looked around and up once more and even expected to hear the coughing renewed, but there was not a sound. Looking again up to the towers he perceived, to his astonishment, that the king was no longer there sculptured in bronze upon his marble horse. But soon he perceived a curious sound, like heavy steps of brazen feet coming down the spiral staircase of the cathedral tower. Soon the portals of the cathedral opened wide, and the workman saw emerging the mediæval king, with his crown, sceptre, and mantle. Looking carefully about, the old king came down the steps, turned toward the statue of Laennec, and finally saluted and pointed to his chest. Laennec, in turn, saluted from his pedestal, seemed to comprehend that his advice was wanted, and then he gravely stepped down to the ground outside the fence surrounding his pedestal. The old monarch motioned to be stethoscoped, Laennec lifted his hand, which bears on his statue an early invented stethoscope, applied it silently to his patient's chest and then to the back, then dropped it, tapped, percussed, and reflected. Finally, on a bit of paper which the king handed him, he wrote a prescription and handed it in silence back again. The two brave old fellows looked at one another briefly in the eyes, and then saluted very ceremoniously with mutual and deep reverential courtesies.

Laennec mounted once more upon his pedestal, and the ancient monarch stepped gravely, silently and majestically to the cathedral doors, which he closed quietly behind him. His steps were then heard slowly climbing the spiral stairway, and at last he emerged from between the two lofty windows on the facade of the cathedral, and mounted once more his horse of bronze.

From that day to this, King Grallon has never coughed again; Laennec had cured him.

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Sunflower
Timothy
Walnut
Willow

Ragweed (*Ambrosia trifida*).

Ragweed (*Ambrosia artemisiaefolia*).

Fritzsche Brothers, Inc.:

Benzyl Benzoate—Fritzsche.

Gilliland Laboratories:

Pertussis Bacillus Vaccine.

Diphtheria Toxin (Antitoxin Mixture.)

Heyden Chemical Works:

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Hynson, Westcott & Dunning:

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